State of Delaware
Department of Correction

PROFESSIONAL SERVICES TO PROVIDE CORRECTIONAL HEALTH CARE SERVICES FOR THE OFFENDERS IN THE DELAWARE DEPARTMENT OF CORRECTION

Due Date:
February 26, 2010, 4:00 PM EST
PIN: DOC09024

Submitted by:

MHM Correctional Services, Inc.
1593 Spring Hill Road, Suite 600
Vienna, VA 22182

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MHM Correctional Services, Inc

February 26, 2010

James C. Welch, RN, HN-BC
Chief, Bureau of Correctional Healthcare Services
Delaware Department of Correction
245 McKee Road
Dover, DE 19904

Re: Mental Health and Substance Abuse Services

Dear Mr. Welch:

As President and Chief Operating Officer of MHM Correctional Services, Inc. (MHM), I am pleased to present our proposal in response to the Department's RFP for *Professional Services to Provide Correctional Health Care Services* (DOC09024). Because approximately 80% of offenders with mental illness also have serious substance abuse disorders, we firmly believe the mental health and substance abuse programs should be combined under a single specialty behavioral health services vendor. For this reason, MHM has chosen to bid on the following two service components:

- **Mental Health Services**
- **Substance Abuse Treatment**

We applaud the Department's decision to carve-out mental health services (eleven states that have purchased mental health services separately have not returned to a comprehensive model). In comprehensive programs where a single vendor is responsible for all aspects of health and mental health services, the mental health program is typically considered *secondary* to the challenges of the larger physical health program. This often results in substandard mental health care, chronic staffing shortages, and the excessive use of costly psychotropic medications. By procuring mental health and substance abuse treatment services separate from general medical services, the Department ensures the highest level of attention is paid to these important programs. In addition to the inherent financial and operational efficiencies, awarding both of these services to MHM will result in better clinical programming and a seamless continuum of care for inmates with both mental health and substance abuse treatment needs.

As the leading national provider of correctional mental health services, now serving over 260 facilities in 14 states, no other correctional healthcare vendor comes close to matching the experience and depth of MHM's resources. The Delaware Department of Correction (DDOC) can expect the following from MHM:

- Expanded mental health and substance abuse services
- Improved continuity of care

- Better management of the utilization of costly psychotropic medications
- Model clinical programs for inmates and better staff training
- Full staffing of mental health and substance abuse program positions
- Lower costs through increased efficiencies
- A transparent, collaborative working relationship

We will achieve these initiatives through effective local program management supported by our expansive, regional corporate resources including MHM's continuous quality improvement and pharmacy management programs, the industry's largest Recruiting Department (including 12 full-time recruiters with an *overall fill-rate of 97% for over 2,000 company positions*), and the return of Dr. Robert "Mike" Hooper to Delaware as our Regional Program Director to enhance the substance abuse treatment programs. Each of these items is discussed further in *Tab 2, Required Information,* and throughout our proposal.

We recognize that we will be working alongside one or more vendors in the provision of healthcare services. As a specialty behavioral health services provider, this is a common scenario for MHM. We typically work alongside a medical vendor and other vendors in each of our contracts, including our nine statewide correctional mental health programs. We invite the State to contact any of our current client agencies who will confirm that MHM has a strong working relationship with all the various medical and pharmacy vendors in our contracts. We are committed to working jointly with our client agencies and other vendor stakeholders to create a successful and cost-efficient program.

As required by the RFP, we attest that no activity related to the performance of this contract will be provided outside of the United States.

I look forward to an opportunity to meet in person and discuss our proposal, the benefits we can offer the State, and the development of a lasting partnership. Please do not hesitate to contact me anytime via phone at (703) 749-4600 or email at swheeler@mhm-services.com.

Sincerely,

Steven H. Wheeler
President and Chief Operating Officer

TAB 2. REQUIRED INFORMATION

SECTION III, REQUIRED INFORMATION

Introduction

MHM Correctional Services, Inc. (MHM) is bidding on the following two service components:

1. **Mental Health Services**
2. **Substance Abuse Treatment**

As mentioned in our *Transmittal letter,* procuring mental health and substance abuse treatment services separate from the general medical services ensures the highest level of attention is paid to these programs. Because approximately 80% of offenders with mental illness also have serious substance abuse disorders, we firmly believe the mental health and substance abuse programs should be combined under a single vendor. Awarding both programs to MHM will maximize financial and operational efficiencies and result in better clinical programming and a seamless continuum of care. Additionally, the State will receive the following benefits, discussed at length throughout our proposal:

- **Expanded and enhanced mental health and substance abuse services** – Both programs will be directed under the supervision of Dr. Robert "Mike" Hooper and supported by our extensive corporate resources. As the leading provider of mental health services in corrections, MHM offers *model clinical programming* for inmates (discussed at length in *Tab 5, Mental Health)*. We propose enhancements to the mental health program through increased training (our library of training modules far exceeds that required by the NCCHC and ACA), superior programming including our highly acclaimed *Taking a Chance on Change* program, lower costs through increased efficiencies, and the introduction of our pharmacy management program. MHM will also work to bring the program in compliance with the additional requirements of the Amended DOJ Agreement.

The substance abuse treatment programs will also be enhanced through a treatment approach and program design using the latest evidenced-based research available when working with offenders with substance abuse histories. This includes the *Phases of Change,* the Therapeutic Community Treatment Model, and interactive journaling which standardizes treatment and ensures offenders receive consistent information (see *Tab 6, Substance Abuse)*.

- **Improved continuity of care** - We are confident that the integration of mental health services and substance abuse treatment services by the same vendor will significantly improve the treatment of offenders who have co-occurring disorders. MHM understands the importance of maintaining a continuum of care, as studies have shown this significantly reduces recidivism. Therefore, MHM mental health staff performing intake screenings on offenders (referred by the medical vendor) will conduct a simple drug and alcohol screen to identify potential candidates early on for drug treatment. This will aid

offenders in need of treatment as well as help ensure all available treatment beds are utilized. Additionally, the proper management of the substance abuse programs will help ensure that inmates complete the full continuum through Aftercare. In addition, MHM's Clinical Operations Department (discussed further below and throughout our proposal) will work with both mental health and substance abuse staff to provide training and consultation for particularly difficult cases.

- **Better management of the utilization of costly psychotropic medications** –Though not directly at risk for the costs of medications, we know full well the significant cost overruns that can occur when psychotropic medications are not properly managed. In a correctional system the size of Delaware, these cost overruns can be measured in hundreds of thousands of dollars, if not millions. Therefore, MHM devotes all the necessary time and resources to every client to ensure that drug costs are managed effectively regardless of who is at-risk for the drug costs. MHM's pharmacy team uses our large national presence to establish what we consider an acceptable average in corrections with regards to cost-per-inmate, market shares of each atypical antipsychotic, market shares of conventional antipsychotics versus atypical antipsychotics, and the average daily dose of each antipsychotic. Our program provides clinicians with valuable guidance that molds their practice patterns to the standard we provide in corrections, and we believe it will enable the DDOC to better manage psychotropic drug use – particularly in regards to atypical medication. For further information, see *Pharmacy Management*, below.

- **Full staffing of mental health and substance abuse program positions -** The State will benefit from MHM's Recruiting Department which includes 12 full-time recruiters with an *overall fill-rate of 97% for over 2,000 company positions*. We have developed an extensive recruiting plan (see *Tab 4, Section X, C.2*) in order to meet the needs of the DDOC. Because we believe retention is as important as recruiting, we seek to minimize vacancies by minimizing turnover.

MHM engages clinicians as *employees* of the company (rather than relying on independent contractors) and provides them with salaried compensation and a variety of employee benefits. Our approach not only meets IRS rules, but results in a more stable and committed workforce dedicated to our mission of client service.

- **Assistance from an expert in litigation resolution -** Litigation has a profound impact on the cost of providing a treatment program by instituting restrictive policies, imposing expensive and inflexible staffing ratios, and mandating the use of costly court monitors. These agreements cast superfluous oversight and operational requirements over the system of care while impeding the true mission of a program: to deliver cost-effective, quality care to inmates.

We commend the Department's achieving compliance with the Department of Justice 2006 Agreement, and recognize the challenges that remain under the Amended Agreement. Senior members of our Clinical Operations team have years of experience resolving consent decrees and similar forms of litigation, and will assist the DDOC in reaching full compliance in the mental health program by enhancing services and

establishing various self-monitoring mechanisms. For example, we will develop a tailored CQI program to include internal audits at a corporate and local level to ensure compliance with accreditation and agency specific protocols, *at no extra cost to the State*. We discuss litigation resolution further under *Litigation Resolution & Avoidance,* below.

- **Understanding and experience working in a dual correctional system -** MHM is fully aware of the fact that the Delaware correctional institutions serve as both jail and prison, meaning they house new arrestees (i.e. pre-trial) as well as sentenced offenders. The jail mission of the institutions means the health and mental health programs must be able to address the acute needs of new arrestees coming in directly from the community at all hours of the day. MHM currently serves over 16,000 jail inmates in our three large urban jail contracts in Atlanta, Philadelphia, and Salt Lake City, plus the Baltimore City Detention Center, which is a component of our contract with the Maryland Department of Corrections. Additionally, we serve over 200 state prisons and have over five years of experience managing a similar jail and prison system in Vermont. No other vendor can claim our level of experience and depth of resources in providing behavioral health services to prison and jail populations.

MHM is the national leading provider of specialized behavioral health services to correctional facilities and currently serves state and municipal agencies in:

- Alabama
- Connecticut
- Georgia
- Maryland
- Massachusetts
- Michigan
- Missouri
- New Hampshire
- New Mexico
- New York
- Ohio
- Pennsylvania
- Tennessee
- Utah

Our contracts include behavioral health programs to state departments of corrections, municipal jails, juvenile justice agencies, and court forensic services. Our large municipal jail contracts are with Dekalb County, Georgia (Atlanta), City of Philadelphia, and Salt Lake County, Utah.

- **A transparent, collaborative working relationship –** MHM does not view itself as a vendor, but as a *partner* with our client agencies. We prefer the term "public-private partnership" to describe the contracting models and agency relationships we operate under with our existing clients. Through this approach, our client agencies partner with MHM to commence an ongoing process of service improvement and continuous cost containment with the cost savings that we identify over time accruing back to the State.

The following information shall be provided in each proposal in the order listed below. Failure to respond to any request for information within this proposal may result in rejection of the proposal at the sole discretion of the DDOC.

A. Minimum Requirements

1. Delaware business license:
Provide evidence of a Delaware business license or evidence of an application to obtain the business license.

MHM is a Delaware corporation and licensed in the State of Delaware. Please review our business license at the end of this *Tab*.

2. Professional liability insurance:
Provide evidence of professional liability insurance in the amount of $5,000,000.00.

We have provided a copy of our insurance at the end of this *Tab*.

3. Vendors must demonstrate that they have had at least 3 years experience in either correctional health care or 3 years experience in medical, mental health, dental, pharmaceutical, medical Specialty Consultation, female health care or utilization review in Delaware.

MHM exceeds this requirement; please refer to the following section, *Corporate Experience*.

B. 1. Corporate Experience

Company's overall related work experience which meets qualifications of RFP, experience in providing correctional health care programs for offender populations up and exceeding 7,000, and current experience in providing them in facilities that are ACA, NCCHC, or JCAHO accredited or providing health care or mental health care in Delaware; Experienced in utilization management and in producing cost savings while maintaining appropriate offender outcomes. Experience should be demonstrated by providing information separately for infirmary and hospital care in the following areas:

a) Admissions per 1,000 offenders or offenders: infirmary, hospital
b) offender days per 1,000 offenders or offenders: infirmary, hospital
c) Average length of offender stay: infirmary, hospital
d) Average length of offender mental health stay
e) Average length of offender chemical dependency withdrawal
f) Mental health admissions per 1,000 offenders or offenders
g) Chemical dependency withdrawal per 1,000 offenders or offenders

If the Vendor has clinical experience in Delaware, the Vendor must provide the above based information on that clinical experience.

In addition, the Vendor should provide a brief description of current or past services similar to those proposed, indicating success of those services and

target population served by the Vendor. Include the number of offenders (offenders) served and a brief description of the types of services provided. Include a summary of the Vendor's current and recent history of past performances related to correctional or clinical health care including all contracts awarded in the past five years.

a) **Indicate capacity to successfully manage proposed services.**
b) **Specify corporate experience in providing correctional or clinical health care. Include in your discussion the number of employees in the firm, annualized dollars of payroll, and number of years in business.**

MHM Corporate Background & Experience

MHM Correctional Services, Inc., (MHM) is the leading provider of mental health services to correctional agencies in the U.S. MHM is a subsidiary of MHM Services, Inc., a Delaware corporation, which boasts over ***28 years*** *of experience* in providing contractual mental health managements services in a wide range of patient care settings, including hospitals, nursing homes, correctional facilities, and community mental health centers. MHM employs over 2,000 clinical, managerial, and administrative professionals nationwide. Our total annualized payroll for full-time and part-time employees is approximately $145,000,000.

MHM entered the correctional mental health market in July of 1997, when we were engaged by the Tennessee Department of Correction to provide psychiatrists and psychologists throughout the state's prison system. Later in that same year, the Georgia Department of Corrections engaged us to provide similar services throughout the Georgia prison system. From these early beginnings in corrections, we have grown steadily and have continuously expanded our service and management capabilities with each new contract. We still have our two original contracts in Tennessee and Georgia, and have added eight other state correctional systems and four large municipal jails to our list of client agencies. *MHM now provides mental health services in 14 states at 256 correctional facilities, and serves a combined population of approximately 275,000 adult, juvenile, male, and female inmates.*

We prefer the term "public-private partnership" to describe the contracting models and agency relationships we operate under with our existing clients. Through this approach, our client agencies partner with MHM to commence an ongoing process of service improvement and continuous cost containment with the cost savings that we identify over time accruing back to the State.

MHM has extensive experience providing mental health services to both Departments of Corrections and large municipal jail systems. Many of the populations we serve exceed 7,000 as evidenced in the table below. We invite the DDOC to contact any of the individuals below as a reference.

MHM Current Contract Summary

Agency Name	Agency Contact Information	Contract Term/Facilities	Contracted Services
Alabama Department of Corrections	**Ruth Naglich** Associate Commissioner, Inmate Health Services **Address:** 301 S. Ripley Street P.O. Box 301501 Montgomery, AL 36130 **P:** 334.353.4049 **F:** 334.353.3967 **E-mail:** ruth.naglich@doc.alabama.gov	**Contract Term** 11/03/03 - 9/30/13 **Renewal Dates** N/A **ADP** 27,915 **No. of Facilities** 29	▪ Comprehensive Mental Health Services ▪ Comprehensive Pharmaceutical Management ▪ Specialized Programs
DeKalb County Jail (Georgia)	**Sheriff Thomas Brown** DeKalb County Jail **Address:** 4415 Memorial Drive Decatur, GA 30032 **P:** 404.298.8145 **F:** 404.298.8101 **E-mail:** tebrown@co.dekalb.ga.us	**Contract Term** 8/19/06 - 8/18/10 **Renewal Dates** 8/18/2010 **ADP** 3,300 **No. of Facilities** 1 Metropolitan Jail	▪ Comprehensive Mental Health Services ▪ Comprehensive Pharmaceutical Management ▪ Suicide Prevention/Crisis Stabilization ▪ Manage & Staff a 27-bed Acute Mental Health Unit: 18 male and 9 female beds ▪ Mental Health Special Housing Unit Management ▪ Discharge Planning ▪ Court Liaison Services ▪ Officer Training

MHM Current Contract Summary

Agency Name	Agency Contact Information	Contract Term/Facilities	Contracted Services
Georgia Department of Corrections	**Jim DeGroot, Ph.D.** Director, Mental Health/Mental Retardation Services **Address:** 2 Martin Luther King Jr. Dr. SE East Tower, Ste. 854 Atlanta, GA 30334 **P:** 404.651.6483 **F:** 404.656.6703 **E-mail:** degroj00@dcor.state.ga.us	**Contract Term** 10/01/97- 6/30/10 **Renewal Dates** N/A **ADP** 46,925 **No. of Facilities** 37	▪ Comprehensive Mental Health Services ▪ Comprehensive Pharmaceutical Management ▪ Suicide Prevention ▪ Crisis Stabilization Units: 38 male beds and 3 female beds ▪ Acute Care Units Overflow: 62-beds ▪ Step Down Units/Isolation Cells ▪ Utilization Review ▪ Dental & Counselor Staffing Management ▪ Female mental health & co-dependency programs at the Metro State Prison in Atlanta
Maryland Department of Public Safety & Correctional Services **Includes the Baltimore City Detention Center & the Baltimore Central Booking & Intake Center*	**Tom Sullivan** Director, Treatment Services **Address:** 300 E. Joppa Road, Ste.1000 Towson, MD 21286 **P:** 410.339.5077 **F:** 410.339.4228 **E-mail:** rrosenblatt@dpscs.state.md.us	**Contract Term** 7/01/05 - 6/30/10 **Renewal Dates** N/A **ADP** 26,748 **No. of Facilities** 34 **Across 4 regions*	▪ Comprehensive Mental Health Services ▪ Comprehensive Pharmaceutical Management ▪ Specialized Programs ▪ 24/7 suicide screenings & evaluations at the Baltimore Booking Center ▪ In-cell Treatment Program for Administrative Segregation

MHM Current Contract Summary

Agency Name	Agency Contact Information	Contract Term/Facilities	Contracted Services

Massachusetts Department of Correction
 	
**Includes Bridgewater State Hospital*
	Terre Marshall
	Assistant Deputy Commissioner of Clinical Services
	
	Address:
	12 Administration Road
	P.O. Box 426
	Bridgewater, MA 02324
	
	P: 508.279.8612
	F: 508.279.8054
	
	E-mail:
	tmarshall@doc.state.ma.us
		Contract Term
		7/01/07 - 6/30/12
		
		Renewal Dates
		6/30/2012
		6/30/2014
		
		ADP
		10,834
		
		No. of Facilities
		17
			▪ Comprehensive Mental Health Services
			▪ Comprehensive Pharmaceutical Management
			▪ 4 Residential Treatment Units
			▪ 1 Secure Treatment Program
			▪ 10-bed Behavioral Management Unit
			▪ Additional Services at Bridgewater State Hospital:
			  ▪ Ancillary & Medical Management
			  ▪ Forensic Evaluations
			  ▪ Expert witness testimony
			▪ Women's mental health services at MCI Framingham
			▪ Mental health services at the Massachusetts Treatment Center

Michigan Department of Community Health & Department of Corrections	**Andy Ghosh, CPPB** Contract Administrator, Purchasing Operations **Address:** Department of Management and Budget Mason Bldg., 2nd Floor P.O. Box 30026 Lansing, MI 48909 **P:** 517.373.7396 **F:** 517.335.0046 **E-mail:** ghosha@michigan.gov	**Contract Term** 6/20/07 - 6/19/10 **Renewal Dates** 6/19/2010 6/19/2011 **ADP** 23,403 **No. of Facilities** DCH: 5 DOC:15	▪ Psychiatry Staffing Services

MHM Current Contract Summary

Agency Name	Agency Contact Information	Contract Term/Facilities	Contracted Services
Missouri Department of Corrections	**Greg Markway, Ph.D.** Chief, Mental Health Services **Address:** 2729 Plaza Drive P.O. Box 236 Jefferson City, MO 65102 **P:** 573.526.6523 **F:** 573.526.8156 **E-mail:** greg.markway@doc.mo.gov	**Contract Term** 7/01/07 - 6/30/10 **Renewal Dates** 6/30/2010 6/30/2011 6/30/2012 6/30/2013 **ADP** 30,500 **No. of Facilities** 21	▪ Comprehensive Mental Health Services ▪ Suicide Prevention/Crisis Stabilization ▪ Sex Offender Assessment & Treatment (276 beds) ▪ Residential treatment/200-bed Social Rehabilitation Unit for male offenders ▪ 45-bed Women's Social Rehabilitation Unit ▪ Specialized treatment services for mentally retarded and developmentally disabled male inmates in a 46-bed Special Needs Unit ▪ Re-entry services for inmates with serious mental impairment ▪ Initial & annual psychological assessment of Capital Punishment Offenders
New Hampshire Department of Corrections **Mental Health Services*	**Robert MacLeod, Ph.D.** Director, Medical & Forensic Division **Address:** 105 Pleasant Street Concord, NH 03302 **P:** 603.271.3707 **F:** 603.271.5643 **E-mail:** rmacleod@nhdoc.state.nh.us	**Contract Term** 1/01/08 - 6/30/11 **Renewal Dates** 6/30/2011 **ADP** 2,516 **No. of Facilities** 3	▪ Comprehensive Inpatient & Outpatient Psychiatric Services ▪ Comprehensive Pharmaceutical Management ▪ Substance Use Treatment Programs ▪ Court-Appointed Forensic Psychiatry Evaluation Services ▪ Secure Psychiatric Units ▪ Residential Treatment Units ▪ Comprehensive Sex Offender Evaluation & Treatment ▪ On-call Psychiatric Services ▪ Forensic Fellow & Residency Services

MHM Current Contract Summary

Agency Name	Agency Contact Information	Contract Term/Facilities	Contracted Services
New Hampshire Department of Corrections **Medical Services*	**Robert MacLeod, Ph.D.** Director, Medical & Forensic Division **Address:** 105 Pleasant Street Concord, NH 03302 **P:** 603.271.3707 **F:** 603.271.5643 **E-mail:** rmacleod@nhdoc.state.nh.us	**Contract Term** 1/01/09 - 6/30/12 **Renewal Dates** 6/30/2012 **ADP** 2,516 **No. of Facilities** 3	▪ Medical & Dental Staffing & Management Services
Ohio Department of Rehabilitation & Correction	**Robert Hammond, Psy.D.** Chief, Mental Health Services **Address:** 770 W. Broad Street Columbus, Ohio 43222 **P:** 614.728.1932 **F:** 614.728.1680 **E-mail:** robert.hammond@odrc.state.oh.us	**Contract Term** 7/01/03 – 6/30/10 **Renewal Dates** N/A **ADP** 33,216 **No. of Facilities** 22	▪ Mental Health Staffing & Quality Management Services
Ohio Department of Rehabilitation & Correction ** Hocking Correctional Facility*	**Annette Chambers** Chief, Bureau of Medical Services **Address:** 770 W. Broad Street Columbus, Ohio 43222 **P:** 614.728.1942 **F:** 614.466.3002 **E-mail:** Annette.chambers@odrc.state.oh.us	**Contract Term** 3/01/06 - 6/30/11 **Renewal Dates** N/A **ADP** 480 **No. of Facilities** 1*	▪ Medical Staffing Management Services **This facility count is included in the total 22 facilities under contract in Ohio*

MHM Current Contract Summary

Agency Name	Agency Contact Information	Contract Term/Facilities	Contracted Services
Pennsylvania Department of Corrections	**Richard Ellers** Director, Bureau of Health Care Services **Address:** 75 Utley Drive, Ste. 101 Camp Hill, PA 17011 **P:** 717.214.8447 **F:** 717.731.7000 **E-mail:** rellers@state.pa.us	**Contract Term** 9/01/03 - 8/31/13 **Renewal Dates** N/A **ADP** 50,000 **No. of Facilities** 27	▪ Comprehensive Mental Health Services ▪ Suicide Prevention/Crisis Stabilization ▪ QI Program ▪ Program Management & Staffing for Special On-Site Mental Health Units ▪ Specialized Outpatient Programs, including a day treatment program for females
Philadelphia Prison System	**Bruce W. Herdman** Deputy Commissioner, Medical & Behavioral Health **Address:** Curran Fromhold Correctional Facility 7901 State Road Philadelphia, PA 19136 **P:** 215.685.7804 **F:** 215.685.7749 **E-mail:** bruce.herdman@prisons.phila.gov	**Contract Term** 9/01/04 - 8/31/10 **Renewal Dates** N/A **ADP** 9,300 **No. of Facilities** 8	▪ Comprehensive Mental Health Services ▪ Comprehensive Pharmaceutical Management ▪ Program Management & Staffing for one female and two male transitional units, totaling 280 beds ▪ Management & Staffing of the 63-bed Acute Care Mental Health Unit **MHM achieved the first state licensure for this unit* ▪ Outpatient Services ▪ Suicide Prevention/Crisis Stabilization ▪ Court Liaison Services ▪ Re-entry Services ▪ Forensic Evaluations
Salt Lake County Jail (Utah)	**Mark Ellsworth** Health Services Administrator **Address:** 3415 South 900 W. Salt Lake City, UT 84119 **P:** 801.743.5542 **F:** 801.743.5587 **E-mail:** mellsworth@slco.org	**Contract Term** 11/01/03 – 3/31/11 **Renewal Dates** 3/31/2013 3/31/2015 **ADP** 2,050 **No. of Facilities** 2 Jails	▪ Comprehensive Mental Health Services ▪ Comprehensive Pharmaceutical Management ▪ Suicide Prevention/Crisis Stabilization ▪ Officer Training

MHM Current Contract Summary

Agency Name	Agency Contact Information	Contract Term/Facilities	Contracted Services
Tennessee Department of Correction	**Leslie Vincent** Acting Director, Mental Health Services **Address:** 4th Floor, Rachel Jackson Building 320 6th Avenue, N. Nashville, TN 37243 **P:** 615.741.1000 x 8159 **F:** 615.532.3065 **E-mail:** jeanine.c.miller@state.tn.us	**Contract Term** 7/01/97 - 12/31/10 **Renewal Dates** 12/31/2010 **ADP** 14,110 **No. of Facilities** 12	▪ Staffing & Management Services ▪ Comprehensive Pharmaceutical Management ▪ Suicide Prevention/Crisis Stabilization ▪ Evidence-Based Care Management (Utilization Review/InterQual)
Tennessee Department of Children's Services	**Albert Dawson** Superintendent **Address:** Woodland Hills Youth Development Center, Department of Children's Services 3965 Stewarts Lane Nashville, TN 37243 **P:** 615.532.2000 **F:** 615.532.8402 **E-mail:** Albert.Dawson@state.tn.us	**Contract Term** 7/01/05 - 6/30/10 **Renewal Dates** N/A **ADP** 180 **No. of Facilities** 2 **Includes the Woodland Hills & New Visions Youth Development Centers*	▪ Psychiatric & Psychological Evaluations and Assessments

Operations

Once a particular contract or program has been executed, MHM employs the following internally developed processes and programs to support and guide the successful implementation of the contract as appropriate:

- National Recruiting System
- Pharmacy Management and Utilization Review
- Clinical Operations and Program Development
- Suicide Prevention/Crisis Intervention Programs
- Peer Review and Performance Management Systems
- Staff Development and Training

- Consent Decree/Litigation Resolution Solutions
- Human Resources/Benefits Management

MHM provides a centralized system of responsible and accountable management supported by operational, technological, and clinical resources. At the local and facility level, we engage experienced and credentialed staff to manage care. For this project, we will establish local program management in Delaware supported by our corporate and regional resources.

Quality improvement principles (ongoing monitoring of contract and clinical performance) and a level of care treatment system serve to streamline and enhance operations. With over 28 years of experience in working with a diverse client base, MHM has achieved operating efficiencies by organizing the following program and contract management functions:

- Maintaining full staffing patterns to reduce litigation risk and foster quality of care, which helps to prevent financial penalties (MHM's vacancy rate for all positions companywide is less than 3% as of the submission of this proposal).

- Providing a peer review mechanism, clinician training, formulary management, and a data management system to review prescribing trends, costs, and treatment efficacy – resulting in reduced costs and better outcomes.

- Bringing nationally recognized best practices for correctional mental health services to each client agency and custom fitting these services to meet the unique needs of each agency.

- Emphasizing the importance of proper evaluation of all inmates at reception/intake and providing individual evaluations in accordance with NCCHC standards. This process is intended to identify inmates with mental illness and /or suicide risk, and to match inmates with appropriate levels of housing and treatment.

- Offering training for medical, mental health, and security staff; and providing an employee orientation program to welcome new staff to MHM, to introduce them to the Department of Corrections, to provide them with the specialized clinical and professional tools needed in a correctional environment, and to enhance staff retention.

No company can match the depth of MHM's clinical resources for behavioral health services. Our vast team of clinical experts – including medical directors, senior psychologists, clinical program managers and clinical operations specialists – is the highest concentration of correctional mental health expertise in the field. MHM boasts the industry's leading Clinical Operations Department comprised of nationally recognized correctional mental health experts who ensure the sharing of best practices among MHM contracts. Each month, the MHM Medical Directors, Psychologists, and

QA Coordinators participate in conference calls coordinated by Clinical Operations to discuss issues, coordinated by Clinical Operations and share ideas and improve clinical infrastructures.

MHM has clinical, administrative, recruiting, human resources, and information technology personnel actively involved in program implementation. A smooth and coordinated implementation process facilitates improved communications, and sets the stage for a successful working relationship throughout the contract term.

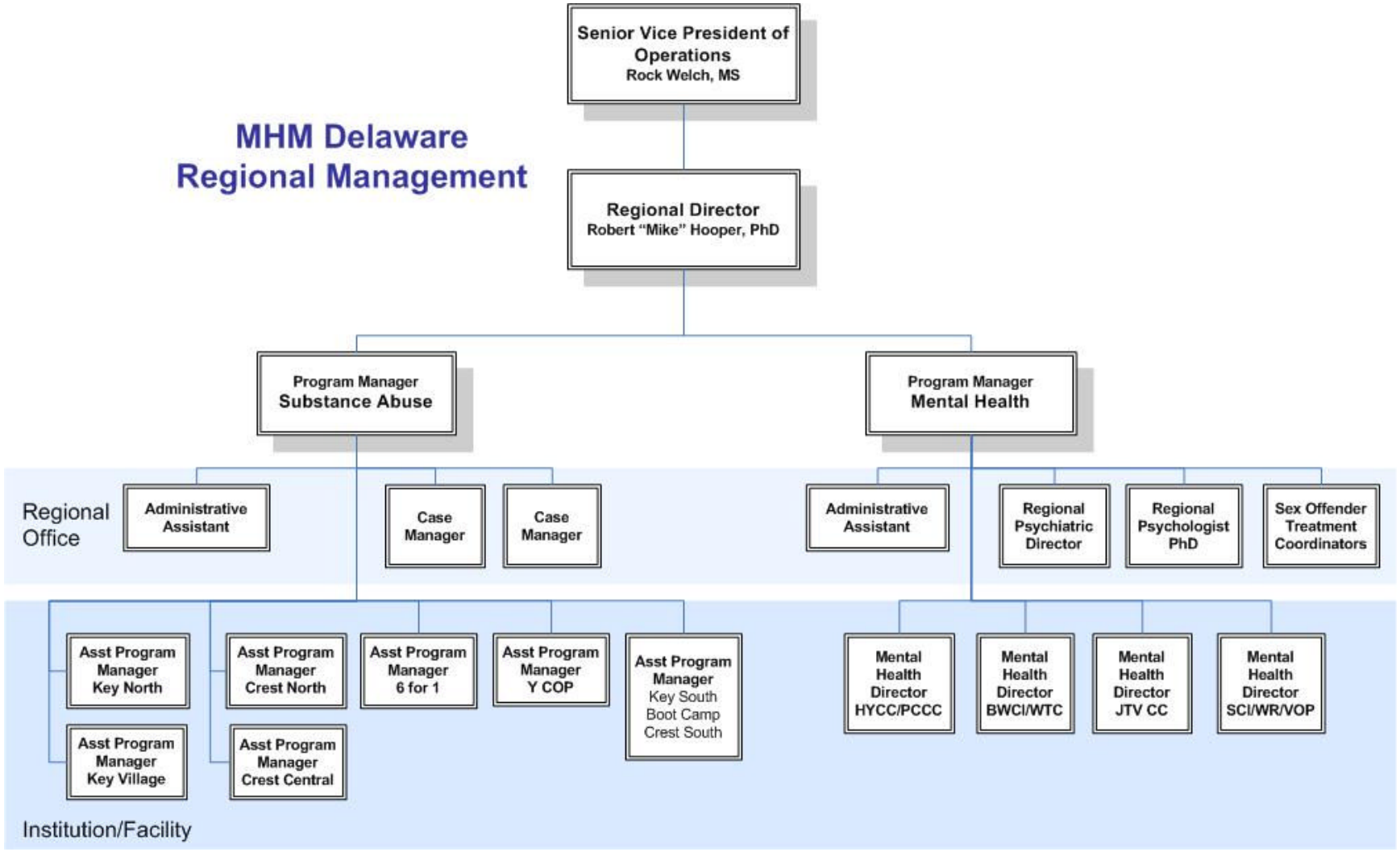
Management

MHM views each client program as distinct and organizes its operations accordingly. Therefore, we establish management positions onsite in addition to regional management to ensure sufficient support and oversight at the institutional level. Program managers implement and follow client agency policies and procedures, or when under a consent decree, operate in accordance with a settlement agreement. To do so, they conduct frequent site visits to prison facilities to review program operations at every level. We establish in-state management and a local office in proximity to our state client offices. MHM will establish a small office in Dover, Delaware to support the program. We also have nearby offices in Baltimore, Maryland to support our statewide correctional mental health program in Maryland, as well as our corporate headquarters in Vienna, Virginia, just outside of Washington D.C.

We will hire a Mental Health Program Manager (referred to as the Mental Health Administrator in the RFP) and a Substance Abuse Program Manager, both residing and working in Delaware. To oversee and manage the overall contract for both services, we will promote Dr. Robert "Mike" Hooper to be the Regional Director over our Maryland and Delaware programs. Dr. Hooper is well known throughout the Delaware DOC, having worked in the Delaware system for 25 years. His return will greatly enhance the substance abuse program and allow for a rapid and smooth transition and start-up phase.

Dr. Hooper reports directly to Rock Welch, MS, MHM's Senior Vice President of Operations, who has over 20 years of correctional healthcare experience. Dr. Hooper will receive corporate support to assist in meeting all aspects of the contract, while preserving autonomy at the local level. All corporate administrative functions including human resources, recruiting, clinical operations, and pharmacy management will support the Delaware program.

We provide an organizational chart on the following page to illustrate the proposed management of both the mental health and substance abuse programs, followed by brief biographies for both Mr. Welch and Dr. Hooper. Their resumes are provided in **Attachment G.**


MHM Delaware
Regional Management
Senior Vice President of Operations
Rock Welch, MS
Regional Director
Robert "Mike" Hooper, PhD
Program Manager
Substance Abuse
Program Manager
Mental Health
Regional Office
Administrative Assistant
Case Manager
Case Manager
Administrative Assistant
Regional Psychiatric Director
Regional Psychologist PhD
Sex Offender Treatment Coordinators
Asst Program Manager Key North
Asst Program Manager Key Village
Asst Program Manager Crest North
Asst Program Manager Crest Central
Asst Program Manager 6 for 1
Asst Program Manager Y COP
Asst Program Manager Key South Boot Camp Crest South
Mental Health Director HYCC/PCCC
Mental Health Director BWCI/WTC
Mental Health Director JTV CC
Mental Health Director SCI/WR/VOP
Institution/Facility

Rock Welch, MS – *Senior Vice President of Operations*

Mr. Welch provides regional oversight of MHM's contracts in Pennsylvania and Maryland; and upon contract award, will provide oversight for the Delaware programs. He provides direction to the MHM Program Managers and oversees all aspects of contractual and client relation functions and directs company-wide resources to ensure the efficient and accountable management of these MHM contracts. Mr. Welch is responsible for contract operations, personnel management, and for maintaining excellent client relations. He reviews all operating indicators and makes recommendations and adjustments in coordination with MHM program managers. Mr. Welch has over 20 years of experience in health and mental health services in correctional settings. He has held progressively responsible positions in health care and mental health treatment teams, and has demonstrated an ability to manage staff in challenging work environments. Mr. Welch is a graduate of Augusta College in Georgia, where he earned a Master of Science degree. His Bachelor of Science degree is from Northern Arizona University.

Robert "Mike" Hooper, PhD – *Regional Director*

Dr. Hooper has over 36 years of experience in correctional mental health services. He is a leading expert in the field of substance dependence and abuse treatment within a correctional health setting and has been instrumental in the development and implementation of such programs in the states of California, Delaware, Maine, New Jersey, South Carolina, and Texas. Dr. Hooper has also been responsible for developing and supervising intensive treatment programs in prisons and jails nationwide. He has coordinated the staff and services of psychiatric and psychology staff as well as medical, dental and mental health staff. He is also an expert in the field of crisis intervention for depressed and violent offenders.

Dr. Hooper is known for his work in substance abuse treatment within the criminal justice field which began in Delaware in 1987 when he worked with staff from DDOC in the creation and on going development of the Key Program. Subsequently he worked with DDOC staff and the Center for Drug and Alcohol Studies, University of Delaware in the development of the Crest Program and Aftercare. His background in the fields of mental health and substance abuse treatment in the criminal justice setting will be utilized in guiding MHM's programs in Delaware.

Academic Affiliations

MHM establishes affiliations with academic institutions in various locations. These academic affiliations provide training opportunities for students and post-graduates and serve as an effective means to expose new behavioral health professionals to the field of correctional mental health. Additionally, these affiliations provide access to the latest, evidence-based treatment approaches and enrich the clinical services MHM brings to our clients. Some of our other academic affiliations include:

- **Harvard University / Massachusetts General Hospital:** Forensic Psychiatry Fellowship Program at Bridgewater State Hospital
- **University of Massachusetts Medical Center:** Forensic Psychiatry Program and Post-doctoral Psychology Program.
- **Boston University:** Post-doctoral Psychology Program
- **University of Pennsylvania:** School of Nursing, Advanced Practice Registered Nurse Program at the Philadelphia Prison System
- **Temple University:** School of Medicine, Department of Psychiatry Program
- **University of Pittsburg:** School of Medicine and School of Nursing Program with the Pennsylvania Department of Corrections
- **University of Bridgeport (CT):** School of Social Work
- **University of Utah:** School of Medicine Residency Program at the Salt Lake County Jail
- **University of Tennessee:** Graduate Psychology Program

Compliance

One of the main factors for any company seeking to manage a large-scale correctional program across multiple facilities is the company's ability to self-audit and ensure compliance with not only contract requirements, but the wide range of applicable policies, procedures, accreditation standards, and discipline-specific practice guidelines. A key issue for many of our correctional client agencies is the achievement and maintenance of accreditation by the National Commission on Correctional Health Care (NCCHC) and/or the American Correctional Association (ACA). The accreditation standards of each of these organizational bodies include specific requirements for mental health services. Routinely, we assist our client agencies in achieving or maintaining ACA and/or NCCHC accreditation, and ensure our service approach meets accreditation standards. MHM has expertise in meeting national accreditation guidelines for correctional health, and complying with state-specific directives and policies. ***Our success rate in meeting accreditation requirements is 100% to date.***

Compliance with NCCHC standards is standard for all MHM contracts even if the client does not require NCCHC accreditation. MHM has developed model policies and procedures and related forms for each NCCHC standard. For further information regarding experience in accredited facilities, please refer to *Section c,* below.

Our Clinical Operations Department, comprised of nationally recognized clinical experts, establishes an auditing and compliance mechanism unique to each of our contracts and conducts regular audits. Reports of these audits are openly shared with our client agencies (see *Tab 3, Section II, B.4.vii.).*

Utilization Management

MHM integrates a process of Utilization Management and Utilization Review (UM/UR) in each of its contracts. Often in correctional settings, we find that a subset of inmates

languish on the mental health caseload for indefinite periods of time – resulting in higher costs for the State. Therefore, we challenge our clinicians to practice in a goal-oriented fashion and target major symptoms and behavioral issues so that inmates may be restored to their highest level of functioning in a timely fashion.

The mission and focus of the services on each mental health unit varies based on the physical resources available, the organization interface of the mental health unit with the rest of the continuum of mental health care in the system, and the requirements of the specific contact. As a result of this variability in mission and focus across contracts, the admission and length of stay data requested by the State is provided by contract rather than aggregate number. The data provided are generally based on records for the first nine or ten months of 2009.

Jail Contracts

- **Philadelphia Prison System (Jail) -** MHM operates four mental health units for the Philadelphia Prison System (PPS). The Inpatient Unit provides 63 cells for male and female inmates. The unit is licensed by the state to provide inpatient psychiatric level services with 24-hour nursing coverage for inmates experiencing acute psychosis or at risk for self-harm. Inmates must meet either voluntary or involuntary commitment criteria under state law to be admitted to the Inpatient Unit. The goal is stabilization of the inmate's acute mental health problems with subsequent transfer to a less intensive level of care.

The average inmate population of the PPS Jail during this period was 9,300 but only 8,810 of these inmates were actually housed within the PPS facilities. Thus, the average monthly rate of inmates admitted to the Inpatient Unit per 1000 inmates was 19.2 during the first ten months of 2009.

PPS Inpatient Unit	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	AVE
Admissions	168	149	151	173	158	153	157	200	176	209	169
Lengths of Stay*	9.6	9.9	13.4	8	10	9.9	10	8	11	6	9.58

* Computed based on length of stay of discharges during each month

MHM operates two male Transitional Units (190 bed capacity) and one female Transitional Unit (130 bed capacity) for PPS. The units function as "step-down" units for the Inpatient Unit and also provide long-term residential services for inmates with chronic mental illness or limited cognitive functioning. While the goal is to assist the inmate in achieving a level of functioning appropriate for placement in general population with outpatient services, some inmates remain on the Transitional Units for their entire incarceration due to seriously compromised functioning. The female Transitional Unit is large and may include the placement of female inmates with mental health issues not at the severity level typically placed in a mental health unit.

Again, the average inmate population of the Philadelphia Prison System during this period was 9,300, but only 8,810 of these inmates were actually housed within the PPS

facilities. Thus, the average monthly rate of inmates admitted to the Transitional Units during this timeframe per 1000 inmates was 14.3.

PPS Transitional Unit	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	AVE
Admissions *(Male)*	37	47	44	60	60	44	41	60	56	–	50
Admissions *(Female)*	66	57	75	85	69	75	66	110	80	–	76
Lengths of Stay* *(Male)*	78	68	66	59	69	58	110	124	193	–	91.66
Lengths of Stay* *(Female)*	85	92	74	98	55	72	111	56	65	–	78.66

*Computed based on length of stay of discharges and inmates still on the unit

- **Salt Lake County Jail -** MHM operates two mental health units for the Salt Lake County (SLC) Jail. The Acute Unit provides a total of 18 cells for male and female inmates. MHM provides the psychiatric and mental health staff coverage. County-employed nurses provide 24 hour nursing coverage. The Acute Unit is intended for inmates experiencing acute psychosis and inmates at risk for self-harm. The goal is stabilization of the inmate's acute problems and discharge to a less intensive level of care.

The average inmate population of the SLC Jail during this period was 2050. Thus, the average monthly rate of inmates admitted to the Acute Unit per 1000 inmates was 24.9 during the first ten months of 2009.

SLC Acute Unit	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	AVE
Admissions	37	53	52	57	63	49	55	53	44	47	51
Lengths of Stay*	8.61	6.98	7.00	7.06	7.65	7.57	10.02	5.47	4.37	4.87	6.96

*Computed based on length of stay of discharges and inmates still on the unit

MHM provides the psychiatric and mental health coverage for the SLC Jail's 48-cell Sub-Acute Unit. The unit provides a supportive environment separate from the general population. This unit functions as a "step-down" unit for the Acute Unit and also provides long-term services for inmates with chronic mental illness or limited cognitive functioning. While the goal is to assist the inmate in achieving a level of functioning appropriate for placement in general population with outpatient services, some inmates remain on the Sub-Acute Unit for their entire incarceration due to seriously compromised functioning.

The average inmate population of the Salt Lake County Jail during this period was 2050. Thus, the average monthly rate of inmates admitted to the Residential Treatment Units per 1000 inmates was 13.2.

SLC Sub-Acute Unit	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	AVE
Admissions	21	22	40	22	26	42	20	29	26	35	27
Lengths of Stay*	59.60	62.95	42.22	33.21	39.14	31.46	35.62	38.55	42.83	34.01	41.96

*Computed based on length of stay of discharges and inmates still on the unit

- **DeKalb County Jail -** MHM operates the Mental Health Stabilization Unit for the DeKalb County Jail. The unit has 18 cells for males and nine cells for females. The unit

provides inpatient psychiatric level services with 24 hour nursing coverage for inmates experiencing acute psychosis or at risk for self-harm. The goal is stabilization of the inmate's acute problems with subsequent transfer to a less intensive level of care.

The average inmate population of the DeKalb County Jail during this period was 3300. Thus, the average monthly rate of inmates admitted to the Mental Health Stabilization Unit per 1000 inmates was 33.0.

DeKalb MH Stabilization Unit	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	AVE
Admissions	103	102	131	120	95	102	95	85	84	85	100
Lengths of Stay*	9.3	10.4	9.8	10.7	14.8	13.6	16.2	16.5	18.4	18.4	13.8

*Computed based on length of stay of discharges and inmates on the unit at end of the month

Prison Contracts

- **Alabama Department of Corrections -** MHM operates five male and two female mental health units for the Alabama Department of Corrections (ADOC).

Two of the male and one female mental health units are Intensive Psychiatric Stabilization Units, with a capacity of 30 and eight, respectively. These units provide inpatient psychiatric level services with 24-hour nursing coverage for inmates experiencing acute psychosis or at-risk for self-harm. The goal is stabilization of the inmate's acute problems with subsequent transfer to a less intensive level of care.

The average inmate population of ADOC during this period was 27,915. Thus, the average monthly rate of inmates admitted to the Intensive Psychiatric Stabilization Units per 1000 inmates was 0.70 during the first nine months of 2009. During the first nine months of 2009, five inmates were transferred to state psychiatric hospitals from the Intensive Psychiatric Stabilization Units after the inmate had completed his/her sentence.

The ADOC Intensive Psychiatric Stabilization Units routinely collect length of stay data for individual inmates admitted to these units but have only recently begun to calculate average lengths of stay.

ADOC Intensive Psych Stabilization Unit	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	AVE
Admissions *(Male)*	20	15	16	12	13	15	20	11	13	–	15
Admissions *(Female)*	13	12	4	1	4	3	3	0	0	–	4.4

MHM also operates the three male and one female Residential Treatment Units for the ADOC. These units provide "day treatment" services in a therapeutic environment separate from the general population. These units often function as "step-down" units for Intensive Psychiatric Stabilization Unit inmates. They provide long-term services for inmates with chronic mental illness or limited cognitive functioning. While the goal is to assist the inmate in achieving a level of functioning appropriate for placement in general

population with outpatient services, some inmates remain on the Residential Treatment Units for their entire incarceration due to seriously compromised functioning.

The average inmate population of the Alabama Department of Corrections during this period was 27,915. Thus, the average monthly rate of inmates admitted to the Residential Treatment Units per 1000 inmates was 0.73 during the first nine months of 2009.

The Residential Treatment Units routinely collect length of stay data for individual inmates admitted to these units but have only recently begun to calculate average lengths of stay.

ADOC Residential Treatment Unit	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	AVE
Admissions *(Male)*	20	18	26	10	17	18	19	13	21	–	18
Admissions *(Female)*	1	3	1	4	1	5	5	2	0	–	2.4

- **Georgia Department of Corrections** – MHM operates 39 male and 3 female Crisis Stabilization Unit beds for the Georgia Department of Corrections (GDOC). These units provide inpatient psychiatric level services with 24 hour nursing coverage for inmates experiencing acute psychosis or at risk for self-harm. The goal is stabilization of the inmate's acute problems with subsequent transfer to a less intensive level of care.

The average inmate population of the GDOC during this period was 46,925. Thus, the average monthly rate of inmates admitted to the Crisis Stabilization Units per 1000 inmates was 2.68.

GDOC Crisis Stabilization Unit**	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	AVE
Admissions	153	120	136	115	116	144	133	125	113	103	126
Lengths of Stay*	6	6	7	8	8	8	8	7	7	9	7.4

*Computed based on length of stay of discharges during the month
**31 of the admissions during this period were female inmates and the average length of stay for female inmates during this period was 3 days

The GDOC also operates acute care beds, state-designated safe calls, state-designated observation cells and supportive living unit beds. MHM staff provide clinical services for these units but do not provide administrative oversight. The state does not regularly provide admission and length of stay data to MHM.

- **Pennsylvania Department of Corrections** – MHM operates three male and one female mental health units for the Pennsylvania Department of Corrections with bed capacities of 45 and 12, respectively.

These units provide inpatient psychiatric level services with 24-hour nursing coverage for inmates experiencing acute psychosis or at risk for self-harm. Inmates must meet either voluntary or involuntary commitment criteria under state law to be admitted to these units. While the goal is stabilization of the inmate's acute problems with subsequent

transfer to general population with outpatient services, some inmates who cannot be safely managed in general population have extended stays.

The average inmate population of the Pennsylvania Department of Corrections during this period was approximately 50,000. Thus, the average monthly rate of inmates admitted to the mental health units per 1000 inmates was 0.88.

As an aside, it is important to emphasize that, despite a growing inmate population and increasing needs for inmate psychiatric services, MHM was able to manage the utilization of mental health beds so effectively that we helped the Pennsylvania Department of Corrections close one of the mental health units at the end of March, 2009. This closure resulted in bed capacity being reduced from 57 to 45 beds for male inmates, or a 21% reduction in capacity, saving personnel, capital, and security costs. MHM's strong CQI and utilization management program enabled us to provide substantial cost savings to the Department of Corrections without compromising mental health care.

PADOC MH Unit	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	AVE
Admissions *(Male)*	48	44	46	41	27	35	31	37	46	–	39.4
Admissions *(Female)*	5	2	6	4	9	6	5	2	4	–	4.8
Lengths of Stay* *(Male)*	33	22	47	24	29	30	30	21	27	–	29.2
Lengths of Stay* *(Female)*	17**	64	47	12	27	17	22	68	16	–	32.2

*Computed based on length of stay of discharges in the month
** Does not include inmate transferred to state hospital after LOS of 595 days

MHM also operates the Daily Adult Interaction Learning Experience (DAILE) unit for the Pennsylvania Department of Corrections. This is an intensive, long-term, "day treatment" program for female inmates who experience significantly compromised functioning due to serious mental illness and cognitive impairment. Program capacity is 25 females. Data collection for admissions was initiated in March of 2009.

Average female inmate population of the Pennsylvania Department of Corrections during this period was 1511. Thus the average monthly rate of inmates admitted to the DAILE program per 1000 female inmates was 1.39 during the first ten months of 2009. Due to the long-term "day treatment" nature of the DAILE program, average length of stay has not been collected to-date.

PADOC DAILE Unit	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	AVE
Admissions	–	–	1	5	5	2	1	1	2	0	2.1

- **Massachusetts Department of Correction** – MHM contracts with the Massachusetts Department of Correction (MADOC) to provide mental health services for the entire prison system and to provide medical and mental health services at Bridgewater State Hospital.

Bridgewater State Hospital is a medium security correctional institution within the Massachusetts Department of Corrections and is the only institution of any type within

the Commonwealth of Massachusetts that also services as a maximum security psychiatric hospital. Bridgewater State Hospital is accredited by The Joint Commission as a behavioral health facility and is also accredited by the American Correctional Association. Bridgewater State Hospital is recognized statutorily by the Massachusetts Department of Public Health as a state hospital.

The mission of Bridgewater State Hospital is to promote public safety, provide court ordered statutorily mandated evaluations of its patients, and treat mentally ill adult men who by virtue of their mental illness are in need of hospitalization under conditions of strict security. Those admitted to Bridgewater State Hospital for these purposes are managed as patients by MADOC and MHM. Patients are admitted to Bridgewater State Hospital for evaluation from the Commonwealth's courts, county houses of correction, county jails and state correctional facilities. Commitments to the hospital are made pursuant to Chapter 123 of the Massachusetts General Laws, and all admissions are the result of a court order.

- Average inmate population of MADOC = 10,834
- Average daily census at Bridgewater State Hospital = 285 (capacity varies by need)
- Patients admitted to Bridgewater State Hospital = 727
- Percentage of MADOC inmates admitted to Bridgewater State Hospital = 6.71%
- Average Length of Stay (ALOS) of Bridgewater State Hospital patients ranged from 6.5 hours to 30 years and was not considered of value in calculating statistics.

Bridgewater SH	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	AVE
Admissions	58	52	63	61	56	80	70	55	74	54	49	55	61

In addition, there are inmates who are housed at Bridgewater State Hospital who have been transferred there via the Department of Corrections classification process. These inmates live in a separate housing unit, "Inmate Unit," and provide maintenance, food service and housekeeping services.

Bridgewater State Hospital houses medically compromised state inmates who are in need of Infirmary services. These individuals are transferred and admitted to the Bridgewater State Hospital Infirmary, per physician order.

Since initiation of the contract with the Massachusetts Department of Correction, MHM has partnered with the client in opening and refining four residential mental health units and a secure treatment unit. Data about admissions and average lengths of stay have not yet been consistently collected.

Pharmacy Management

Psychotropic medications are one of the highest cost line-items in a correctional healthcare budget. MHM has a dedicated Pharmacy Management Department that assists

with each of our contracts. The pharmacy team consists of a doctoral level clinical pharmacologist and a registered pharmacist plus two pharmacy financial analysts. The team works in collaboration with the Medical Directors/Regional Psychiatric Director for each program to ensure the appropriate and effective use of medications through development and implementation of pharmacy management initiatives tailored for each contract. These initiatives include the development of clinical practice guidelines and training programs for psychiatrists. Our corporate pharmacologists often travel to contract locations to meet with psychiatrists, medical directors, and our client agencies to provide feedback about pharmacy utilization and give presentations on more efficient alternatives for treating common diagnoses in correctional populations. Because the drug market is constantly changing, our pharmacologists monitor pricing and dosage issues for psychotropic medications and keep our team of medical directors up to date on best practices.

On a monthly basis, our Clinical Operations Department holds a conference call with the MHM Medical Directors/Regional Psychiatric Directors, during which these best practices and medication management issues are discussed.

MHM's pharmacy team uses our large national presence to establish acceptable target averages in corrections with regards to cost-per-inmate, market shares of each atypical antipsychotic, market shares of conventional antipsychotics versus atypical antipsychotics, and the average daily dose of each antipsychotic medication.

Data on individual contracts and clinicians are compared to these national averages and used for educational purposes to encourage the use of the most cost-effective drugs at the lowest effective dose. Our program provides clinicians with valuable guidance that molds their practice patterns to the standards established for each program. As a result, we save the client money and reduce the side-effect burden for our patients.

Furthermore, we utilize a program of psychiatric peer review whereby individual psychiatrists review the work of their colleagues and provide feedback to each other. For prescribers whose practices appear significantly out of the norm, we provide one-on-one supervision from the Medical Director, and their practices are continuously monitored. In most cases, prescribers who are out of the norm embrace the comparative process and adopt new practices to bring them in line with expectations.

Pharmacy Program Leadership

Gregg Puffenberger, PharmD, Director of Pharmacy Management provides leadership for all contract programs. Dr. Puffenberger implements medication management initiatives for each of the company's programs, and tracks utilization and prescription metrics to ensure optimal usage, compliance, and cost-effectiveness. He facilitates collaboration with medical and pharmacy providers for our multivendor contracts. Dr. Puffenberger has over 20 years of experience in clinical coordination, medication management, and pharmacy utilization assessment. He also has 15 years of experience in pharmacy management, both in medical and psychiatric settings. Dr. Puffenberger earned

a Doctorate of Pharmacy from the University of Maryland and a Master in Business Administration from Shenandoah University. He earned his Bachelor of Science in Pharmacy degree from West Virginia University.

Dr. Puffenberger is assisted by *Vince Grattan, RPh,* Manager of Pharmacy Management who has over 12 years of experience in formulary management and is responsible for providing pharmacology services, including the analysis of usage, pharmacology, dosing, and scripting trends and data. He also negotiates contracts with pharmacy vendors with the goal of reducing expenses while providing the medically necessary treatment of patients. Mr. Grattan works with Medical Directors to implement and monitor psychopharmacological treatment protocols and to develop the data needed to provide prescribing guidance for psychiatrists and nurse practitioners.

Accounts Mr. Grattan has managed include the Pennsylvania Department of Corrections and Corrections Corporation of America, among others. He joined MHM with years of specialized expertise in: Pharmacy Benefit Management (PBM); 340B; and psychopharmacology, Hepatitis-C management, and substance abuse among the incarcerated.

Mr. Grattan earned a Bachelor of Science in Pharmacy from the University of Pittsburgh School of Pharmacy, where he graduated with honors. He is a member of various Pharmacy and Therapeutics Committees, including those of the Departments of Corrections in Pennsylvania, Montana, South Dakota, Kentucky, and Tennessee.

In addition to our two pharmacists, two pharmacy financial analysts comprise the pharmacy management team. They conduct trend analysis and compliance audits and provide valuable information back to each program regarding the program's pharmacy utilization and the appropriate and effective use of medications. Each month, all contracts are reviewed for quality assurance and utilization review.

We budget resources to this department so that our pharmacists can travel to our contracts as needed to provide training to our doctors and feedback to our managers and clients on their medication utilization. Additionally, our pharmacists attend various meetings including Pharmacy and Therapeutics Committee Meetings, Quality Improvement Meetings, and others as requested by the client.

MHM's pharmacists are available to provide consultation and have done so in numerous areas for various clients addressing automated dispensing systems, Pharmacy Benefit Management (PBM), manufacturer rebates, medical as well as psychiatric medications, electronic medical records, pharmacy regulations, and more.

For a sample of our Pharmacy Monthly Reporting Package see **Attachment A.**

Prescriber Education & Monitoring

We have quarterly, and in some cases monthly, phone conferences and face-to-face meetings in our programs to keep our staff up-to-date with the rapid changes that occur in medicine. Our pharmacists spend a great deal of time giving presentations to our prescribing staff on the latest treatment issues for all common diseases in a correctional setting. Further, formulary compliance monitoring is done for each program with the help of highly skilled data analysts. These analysts take raw pharmacy data and transform it into graphs and charts enabling us to identify prescribing trends and assure our clients that our clinicians are making a positive financial impact by adhering to formularies and treatment guidelines.

We have noted in recent years as we hire clinicians who have recently graduated that they are less familiar with some of the older medications that are no longer promoted by drug companies. Some state governments have noticed this bias in favor of new medications and have hired their own "drug reps" to go around the state and educate clinicians on the benefits of older medications. We have similar training programs for our clinicians to help them become comfortable prescribing the older, less expensive medications as well as newer medications. Finally, we have training programs for our new hires to make sure they understand the differences between practicing in the community versus corrections. In particular we focus on medications with abuse potential that may not be obvious to someone unfamiliar with the correctional practice setting and other reasons why our patients might malinger for some other secondary gain.

Outcomes

MHM practitioners prescribe over $26 million a year in psychotropic medications throughout our various contracts. Although in most contracts, we are not directly responsible for the payment of psychotropic medication costs, we take responsibility for their utilization and the cost impact of these medications on our client agencies.

Our mental health expertise in the management and treatment of inmates in correctional systems coupled with our Pharmacy Management Program and strong orientation and training practices for prescribers consistently results in cost savings for the agencies we serve. We have achieved these cost savings despite the rising costs of psychotropic medications. An example of the savings we have incurred for correctional agencies is included in the Pharmacy Management table which follows.

Pharmacy Management: Examples of Cost Savings Results	
Agency	***Savings***
Florida Department of Corrections Region IV	$1.47 M
Georgia Department of Corrections	$1.45 M
New Hampshire Department of Corrections	47% savings in 2008

Pharmacy Management: Examples of Cost Savings Results	
Agency	***Savings***
Pennsylvania Department of Corrections	$12 M from 2003 through 2007 (cost avoidance)
Salt Lake County Jail	Decreased by 15% or approximately $100,000 in 2008
Tennessee Department of Correction	$1,446,000 cost reduction from Jan. 2008 – Nov. 2009
Vermont Department of Corrections	51% decrease in average monthly psychotropic costs from 2006-2009

Litigation Resolution & Avoidance

Litigation has a profound impact on the cost of providing a treatment program by instituting restrictive policies, imposing expensive and inflexible staffing ratios, and mandating the use of costly court monitors. These agreements cast superfluous oversight and operational requirements over the system of care while impeding the true mission of a program: to deliver cost-effective, quality care to inmates.

MHM has extensive experience in resolving litigation with new clients and avoiding litigation in all of our current contracts by implementing a program featuring proven components such as our CQI Program (see *Tab 3, Section II, B.4.vii*) and self-monitoring mechanisms.

One such example is with our Georgia Department of Corrections (GDOC) contract. This program began in 1997 when MHM was awarded a contract to provide mental health and medication management services to its 40,000 inmates. Prior to that time, the program was involved in issues that ultimately led to the *Cason vs. Sekenger* lawsuit and settlement agreement in 1995.

MHM worked closely with the GDOC and the appointed court monitors, which included Dr. Jeffrey Metzner, to identify the underlying issues that they felt needed to be prioritized, and to develop a comprehensive mental health program that addressed these issues. *In less than 2 years, the monitors were satisfied enough with the progress of the program that they recommended lifting the court order and relinquishing their roles as monitors.* Dr. Metzner was retained by the Department to continue as an expert consultant to ensure that all subsequent cost cutting measures met the intent of the settlement agreement's concerns for the system.

MHM also worked with the DeKalb County Jail in Atlanta, Georgia to achieve a final resolution of the *Adams v. Dorsey* Settlement Agreement. Although mental health was not cited in the Settlement Agreement, mental health was included under the monitoring of overall medical care. The court monitor made recommendations and required specific systems related to mental health services that we implemented to the satisfaction of the court monitor.

MHM manages correctional mental health programs by assisting clients in resolving prior litigation and avoiding future litigation. The routine program audits conducted by our Clinical Operations Department focus on any litigation related mandates and identify potential areas of liability for our client agencies. Before joining MHM, Jane Haddad, PsyD, our Vice President of Clinical Operations, provided consultation services to state and county mental health and correctional agencies on compliance and quality management issues. Dr. Haddad was the Court Monitor for the *Bradley* Settlement Agreement addressing the services provided by the Alabama Department of Corrections for male inmates with serious mental illness. She was also the Mental Health Auditor for the *Laube* Consent Decree concerning mental health services for female inmates incarcerated by the Alabama Department of Corrections. Dr. Haddad was a member of the monitoring team for the *Dunn* Consent Decree addressing the mental health services in the Ohio Department of Rehabilitation and Correction. She also served as the Court Monitor for the Evans Consent Decree regarding community-based services for persons with mental retardation and developmental disabilities in the District of Columbia.

As mentioned previously, we commend the Department's achieving compliance with the Department of Justice (DOJ) 2006 Agreement, and recognize the challenges that remain under the Amended Agreement. MHM will assist the DDOC in reaching full compliance in the mental health program, paying particular attention to the following per DOJ requirements:

- NCCHC standards
- Credentials of mental health staff
- Screening and assessment for mental health conditions and suicide risk
- Maintaining accurate mental health records
- The management of psychotropic medications
- Generating appropriate mental health treatment plans
- Maintaining full staffing
- The use of least restrictive alternatives (therapeutic restraint policy)

Evidence of Success

As mentioned above, we have had success in many of our contracts lowering the costs of psychotropic medication while *maintaining* or *even improving* the quality of care through pharmaceutical management. Additionally, we work diligently with each of our clients on continuously improving the quality of services and looking for cost-efficiencies. Below, we provide examples of successes we have reached in partnership with a number of our client agencies.

- **Alabama Department of Corrections** - Prior to engaging MHM, the Alabama DOC had endured years of serious class action litigation pertaining to its mental health program. MHM's role in the early years of the contract was to satisfy the court settlement agreements that called for a complete overhaul and expansion of the mental health program. MHM was charged with the task of expanding the

mental health program by developing and filling over 100 new mental health staff positions. We worked closely with the assigned court monitor, Dr. Jane Haddad, until the requirements of the court were met. Today, MHM continues to satisfy the requirements of the court, and Dr. Haddad has joined MHM as our Vice President of Clinical Operations.

- **Georgia Department of Corrections** - Over the years, we have been successful in implementing managed care strategies that have lowered the length of stay in Crisis Stabilization Units, controlled medication costs, and satisfied court settlement agreements from historical litigation. When we entered this contract in 1997, the State was in the process of addressing court settlement agreements stemming from longstanding litigation pertaining to inmate health services. We assisted the Department in meeting the requirements of the court settlement agreements and resolving the litigation.

- **Maryland Department of Public Safety & Correctional Services -** As a value-add, we developed the *Taking a Chance on Change* program in 2006 (see *Tab 5, Section IV, g)*. This program is designed to encourage inmates in segregation to become engaged in the process of self-improvement. The program has been extremely well received and testimonials from wardens and deputy wardens indicate a high degree of satisfaction with the program. Since its initial development, the program has met with such success that we have implemented it throughout many of our contracts including Alabama, Tennessee, and Missouri.

- **Massachusetts Department of Correction** – MHM initiated many new programs for the prison system. These include recruiting and hiring mental health clinicians and other adjunct staff for the creation of the Behavioral Management Unit for males at MCI Cedar Junction and for the behavioral management programming and day treatment programs at MCI Framingham. MHM clinicians also created a two-track day treatment program for the women at MCI-Framingham, and we are also expanding behavioral management services at MCI Framingham. Additionally, we are also in the process of helping the Department design a 17-bed Emergency Stabilization Unit. We engaged nationally recognized experts to provide training on behavioral management principles to all clinicians. We accepted the Department's mandate to provide mental health services to the female population within a trauma-informed delivery model.

- **Missouri Department of Correction** – MHM has saved the Missouri DOC approximately $1M per year in pharmacy savings. We also successfully transitioned psychiatrists from independent contractors to our employee model and improved scheduling. As evidence of our success in Missouri, the State recently moved forward with the early award of all the optional extension years on our contract.

- **New Hampshire Department of Corrections** – In the early months of this contract, we focused on improving the efficiency of psychiatry services and assisting the Department with enhancements to the mental health program. This contract called for a number of new clinical positions, and at start-up there were

13 clinical and 3 administrative vacancies. Within three months, MHM accomplished a 90% fill rate of all positions. Further, we increased psychiatric staffing in the Secure Psychiatric Unit by 300% and in the general prison population by 200%.

The New Hampshire DOC has engaged MHM for the provision of certain medical staff positions as a result of MHM's proven abilities to recruit qualified clinical professionals to work in the New Hampshire correctional setting.

- **Ohio Department of Rehabilitation & Correction** – Our scope of services in Ohio has continually grown over the years. Major program accomplishments include:
  - Effective recruiting and retention
  - Development and implementation of a formulary management program
  - Implementation of an annual peer review process
  - Development and implementation of new quality improvement studies
  - Training programs for security staff

- **Pennsylvania Department of Corrections** – One of our early major successes in this contract was through our program of medication management and utilization review, which resulted in savings to the Pennsylvania Department of Corrections of over $2 million in two years. Through the MHM Specialized Utilization Review Program (a uniform management of mental health units and long-term chronic care inmates), we produced a decrease in the overall number of inpatient beds and an increase in positive outcomes for inmates in our care. For the first time in the history of the inpatient units, we have achieved consistency in policy and procedures across all inpatient mental health units in the correctional system. Each of these units continues to receive annual re-certification from the Pennsylvania Department of Welfare. Also, our ongoing provision of the Daily Adult Interactive Learning Experience or DAILE program (a specialized program for mentally ill inmates), resulted in increased functioning, decreased disciplinary infractions, and decreased inpatient bed utilization by difficult-to-treat female inmates. Most recently, we have developed a statewide web-based scheduling and productivity infrastructure.

- **Tennessee Department of Correction** – We provide staffing and management services, suicide prevention/crisis stabilization, evidence-based care, and formulary management for an average daily population of 14,000 inmates at 12 facilities. We pioneered a number of our management and reporting systems in Tennessee that are common to our other programs. We recently implemented an evidence-based care management and utilization review program known as InterQual to ensure the efficient use of resources.

The contract has been re-bid on two occasions, and we have been successful in winning both bids and retaining the contract – demonstrating our ability to meet the State's needs.

c) Specify facilities that the Vendor operates that are currently accredited and non-accredited. Include the following information:

i. Name of facility, accrediting agency (e.g., NCCHC, JCAHO), and dates of re-accreditation. List facilities that lost accreditation and the reason.

As mentioned throughout our proposal, ***MHM's success rate in meeting accreditation requirements is 100% to date.*** Therefore, there are no facilities we have served that have lost accreditation to date. Below, we have listed recent facilities that have received accreditation or reaccreditation.

NCCHC		
Name of Facility	**Date of Initial Accreditation**	**Date of Last Reaccreditation**
Philadelphia Prison System		
Alternative and Special Detention	March 14, 2008	March 14, 2008
Curran-Fromhold Correctional Facility (CFCF)	August 25, 2004	July 16, 2008
Philadelphia Detention Center	August 25, 2004	March 14, 2009
House of Correction	June 25, 2004	March 14, 2008
Philadelphia Industrial Correctional Center	June 25, 2004	March 18, 2008
Riverside Correctional Facility	January 19, 2007	Pending - March, 2010*
Cambria Community Corrections Center	August 25, 2004	March 14, 2008
Various		
The Salt Lake County Jail Inmates	1983	March 2007
The Massachusetts Department of Correction	All Institutions are accredited	
Bridgewater State Hospital (MA)	Accredited**	
Baltimore Central Booking and Intake Center	Accredited	
Baltimore City Detention Center	Accredited	
The Missouri Department of Corrections	21 Out of 23 are accredited	

*Awaiting letter of reaccreditation, on-site survey took place on July 23, 2009
**Also accredited by The Joint Commission

ACA		
Name of Facility	**Date of Initial Accreditation**	**Date of Last Reaccreditation**
Tennessee Department of Correction		
Morgan County Correctional Complex		October 2009
Charles Bass Correctional Complex	August 2000	August 2009
DeBerry Special Needs Facility	August 1994	March 2009
Mark Luttrell Correctional Complex	January 1989	September 2009
Northeast Correctional Complex	August 1999	April 2008
Northwest Correctional Complex	August 2000	January 2009
Riverbend Maximum Security Institution	April 1992	April 2007
Southeastern Tennessee State Regional Correctional Facility	January 1988	September 2008
Tennessee Prison for Women	January 1989	January 2010
Turney Center Industrial Prison & Farm (Main and Annex)	April 1992	April 2007
West Tennessee State Penitentiary	January 2001	September 2007
Pennsylvania Department of Corrections		
SCI-Albion	August 1996	August 2008
SCI-Cambridge Springs	August 2006	August 2008
SCI-Camp Hill	November 1984	January 2009
SCI-Chester	January 2000	January 2009
SCI-Coal Township	August 1997	August 2009
SCI-Cresson	January 1989	January 2010
SCI-Dallas	May 1984	January 2009
SCI-Fayette	August 2006	August 2009
SCI-Forest	August 2006	August 2009
SCI-Frackville	August 1993	January 2009
SCI-Graterford	August 2006	August 2007
SCI-Greene	August 1996	August 2008
SCI-Greensburg	August 1982	January 2008
SCI-Houtzdale	August 1995	August 2007
SCI-Huntingdon	May 1984	January 2009
SCI-Laurel Highlands	August 2006	January 2010
SCI-Mahanoy	August 1996	August 2008
SCI-Mercer	May 1984	January 2009
SCI-Muncy	January 1986	January 2010
SCI-Pine Grove	January 2006	August 2009
Quehanna Boot Camp	January 2010	January 2010
SCI-Retreat	January 2004	January 2010
SCI-Rockview	August 1983	January 2008
SCI-Smithfield	January 1991	January 2009
SCI-Somerset	March 1997	August 2009
SCI-Waymart	January 2000	April 2009

Medical Association of Georgia		
Institution	**Date of Initial Accreditation**	**Date of Last Reaccreditation**
Georgia Department of Correction		
Arrendale State Prison	October 1984	January 2010
Augusta State Medical Prison	May 1986	June 2009
Autry State Prison	March 1997	March 2009
Baldwin State Prison	May 1986	October 2009
Bostick State Prison	October 1990	October 2009
Burruss Correctional Training Center	January 1989	January 2010
Calhoun State Prison	August 1996	August 2009
Central State Prison	February 1985	January 2010
Coastal State Prison	April 1992	September 2009
Dodge State Prison	June 1985	October 2009
Dooly State Prison	December 1996	December 2009
Georgia Diagnostic and Classification	November 1986	January 2010
Georgia State Prison	December 1984	November 2009
Hancock State Prison	March 1995	March 2009
Hays State Prison	March 1994	March 2009
Johnson State Prison	July 2010	July 2009
Lee State Prison	June 1988	January 2010
Macon State Prison	March 1996	March 2009
Mens SP	August 1986	April 2009
Metro State Prison	June 1987	July 2009
Montgomery State Prison	September 1984	June 2009
Phillips State Prison	June 1993	June 2009
Pulaski State Prison	June 1997	December 2009
Rogers State Prison	November 1984	November 2009
Rutledge State Prison	September 1983	January 2010
Smith State Prison	August 1996	October 2009
Telfair State Prison	July 1995	July 2009
Valdosta State Prison	October 1991	October 2009
Walker State Prison	August 1997	August 2009
Ware State Prison	August 1994	August 2009
Washington State Prison	September 1996	September 2009
Wilcox State Prison	December 1996	December 2009

ii. List all fines which exceed $1,000, incurred under other contracts for non performance of duties, in whole or in part, within the last three years.

The high level of service provided by MHM, going well beyond meeting our contractual obligations, along with the efforts to work in partnership with our clients has resulted in the infrequent and minimal imposition of penalties of any nature. Following are penalties exceeding $1000 incurred during the last three years (calendar years 2007 through 2009) as requested:

Maryland Department of Public Safety and Correctional Services
January 18, 2007 to December 31, 2007.
Minor contractual issues occurring throughout the 11.5 month period totaling $86,000. Primarily related to contract staffing. Currently under contract with no assessments since 2007.

Tennessee Department of Corrections
$9,000 during the calendar year 2008
$10,000 during the calendar year 2009
Related to minor contract performance measures. Program under contract since 1997.

iii. List all contracts on which you experienced a loss of funds due to fines, delay damages, liquidated damages, and/or forfeiture of performance or proposal bonds in whole or in part.

MHM has never experienced a forfeiture of performance or proposal bonds. Loss of funds on contracts for other reasons have been minimal as stated above.

iv. Submit the names, business addresses, telephone numbers, and fax numbers of at least five of your major suppliers and/or sub vendors in the last five years.

Knowledge Bank
PO Box 398 Fairfax Station, VA 22039 P:703.448.8070 F:703.448.8465
Kelly & Associates
301 International Circle Hunt Valley, MD 21030 P: 410.891.2621 F:527.527.5904

Diamond Drugs, Inc.
PO Box 200796 Pittsburgh, PA 15251 P: 724.349.1111 F: 866.804.8999
JPE Healthcare Staffing
5665 Atlanta Highway, Suite 103-102 Alpharetta, GA 30004 P: 800.980.6511 F: 866.783.1708
Staff Care
P O box 281923 Atlanta, GA 30384 P: 469.524.1473 F: 469.524.1404

v. Name of any facilities owned or operated by Vendor that are on probation.

N/A. MHM does not own or operate any facilities.

vi. Provide the most recent NCCHC or another accreditation agency survey for all facilities.

Providing recent surveys for all facilities would be prohibitively voluminous. Therefore, we have provided samples of recent NCCHC and ACA accreditation surveys, as well as samples from The Joint Commission and other accrediting agencies in **Attachment B.** Additional surveys are available upon request.

B.2. Quality of Response

Understanding of project requirements and ability to clearly describe how their program will meet RFP objectives. Implies judgment of evaluators on how reasonable the Vendor's plan is given particular requirements of the Delaware correctional system. In addition, pricing models with be considered.

MHM currently provides correctional behavioral health programs to ten state-wide correctional systems, each with unique challenges and needs. We are accustomed to designing staffing patterns, treatment programs, and management systems to meet the unique needs of each agency we serve.

We are fully aware of Delaware's desire to improve its mental health and substance abuse treatment programs while containing costs. We understand the Department's litigation history and needs regarding satisfying the various parties to the litigation; and are aware of the dual prison/jail role of the Delaware correctional facilities and the distinct differences this dual mission poses compared to other state prison systems.

Throughout the mental health and substance abuse treatment components of the RFP, we have tailored our responses to show how our services and management systems will meet the specific needs of the Delaware system. The clinical and managerial components of our proposal were developed by the actual clinical leaders and managers within the company who will directly oversee the operations of the Delaware program. These individuals reviewed the Delaware RFP, as well as volumes of other Delaware material, and provided input for this response.

B.3. CORPORATE CAPABILITY

Financial stability as determined by review of financial information provided by the Vendor; perceived ability to start up and manage the program in the time required using the staff, structure and phase in required in the RFP. Financial stability should be demonstrated through production of balance sheets and income statements or other generally accepted business record for the last 3 years that includes the following: the Vendor's Earnings Before Interest & Taxes, Total Assets, Net Sales, Market Value of Equity, Total Liabilities, Current Assets, Current Liabilities, and Retained Earnings.

In addition to financial information, discuss any corporate reorganization or restructuring that has occurred within the last three years and discusses how the restructuring will impact the Vendor's ability to provide services proposed. Also disclose the existence of any related entities (sharing corporate structure or principal officers) doing business in the field of correctional health care. The DDOC reserves the right to terminate the contract, based upon merger or acquisition of the Vendor, during the course of the contract. Include a description of any current or anticipated business or financial obligations, which will coincide with the term of this contract.

As a privately held company, MHM is providing audited financial statements for the fiscal years 2007, 2008, and 2009 as proprietary and confidential information (see *Sealed Envelope)*. Unaudited statements for the most recent period ended December 31, 2009 are also included in the enclosed confidential envelope. Since MHM is a privately held company, the Market Value of Equity is not available.

MHM's underlying financial strength and stability are evident from a review of these financial statements. Positive earnings performance and growth over the last several years continued in fiscal 2008 with a 29% growth in net income over 2007. Net income

in fiscal 2009 grew by an additional 11% over fiscal 2008. The strong earnings performance has contributed to a solid balance sheet with significant excess cash.

In March 2008, MHM's Board of Directors decided to utilize a portion of this excess cash, leverage the positive balance sheet, and repurchase a large number of shares. This stock restructuring, which resulted in a significant change in the company's equity, is reviewed in detail in the notes accompanying and as a part of the enclosed statements. MHM secured new credit facilities with Wachovia Bank, NA on March 31, 2008 to finance the stock repurchase. The credit facilities consisted of a term loan of $40 million which matures on September 30, 2013 and a revolving line of credit of $15 million.

MHM's continued financial strength is demonstrated by the ability to make prepayments in excess of $7 million on the above term loan. These prepayments, along with scheduled principal payments, have reduced the term loan balance by approximately $18 million to approximately $22 million as of December 31, 2009.

As of December 31, 2009, the entire revolving line of credit of $15 million, which matures on March 31, 2011, is available to support current and future cash needs. The flexibility and security represented by this significant line of credit is augmented by the continued accumulation of cash due to positive earnings. The enclosed December 31, 2009 statements reflect a cash balance in excess of $13 million. MHM is well positioned to meet current and future financial obligations, including those inherent in this RFP.

MHM's ability to secure new contracts and maintain existing contracts demonstrates market confidence in the company. We are viewed as a solid and viable company consistently meeting all aspects of contract compliance with both internal and contract specific performance targets. MHM has never had a contract terminated by a client for failure to comply with or meet financial or performance obligations.

Other wholly owned subsidiaries of MHM Services, Inc. include MHM Solutions, Inc., MHM Indiana, Inc., MHM Ohio, Inc., MHM Maryland, Inc. and MHM Forensic Services, Inc. The financial statements provided for MHM Services, Inc. that accompany this proposal are all inclusive of the financial results of these subsidiaries.

B.4. PRICE

Relative cost-effectiveness of service offered in the proposal based on the total dollar figure for delivery of all services for the contract period. Explains how pricing model affords lowest cost without sacrificing quality. "What if" scenarios should be run to fully evaluate each proposed model should actual prices be above or below the proposed target. The transparency of the different pricing models will also be considered.

Please refer to *Tab 7, Cost Proposal.*

B.5. REFERENCES

Verified customer and subcontractors' references from similar operations based on the reported degree of satisfaction of services. Consider significance of reported performance against contract requirements and litigation, past and current, and success in obtaining and maintaining NCCHC or similar standards in correctional systems of similar scope.

Please refer to our Current Contract Summary in *Section B.1*, above. *We invite the DDOC to call any of our clients as a reference*.

Litigation History

In the ordinary course of business, the Company, its subsidiary, MHM Correctional Services, Inc., and clinicians employed by Correctional Services may be the subject of lawsuits filed by inmates of correctional institutions at which MHM Correctional Services provides mental health care. Inmates in such cases frequently are not represented by counsel and typically allege deficiencies in the mental health care they have received under either the Eighth or Fourteenth amendments. The Company maintains insurance with an A rated (Best) firm to cover such claims, subject to a self-insured retention. To date, all defense costs and settlements in the above-described matters have fallen within the Company's self-insured retention amount. The Company does not view such matters as potentially having any materially adverse effect on the Company's operations or its ability to perform the services called for in the Request for Proposals.

The other type of claims MHM has encountered are suits or administrative claims filed by employees or former employees. As with the above-referenced types of matters, the Company maintains insurance to cover such claims, and the Company is not aware of any such claims that fall under the parameters of subparagraph (M). The Company does not view such matters as potentially having any materially adverse effect on the Company's operations or its ability to perform the services called for in the Request for Proposals.

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "MHM CORRECTIONAL SERVICES, INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE FOURTH DAY OF DECEMBER, A.D. 2009.

AND I DO HEREBY FURTHER CERTIFY THAT THE FRANCHISE TAXES HAVE BEEN PAID TO DATE.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

Jeffrey W. Bullock, Secretary of State

2759003 8300

091069134

AUTHENTICATION: 7677311

DATE: 12-04-09

You may verify this certificate online at corp.delaware.gov/authver.shtml

State of Delaware
Division of Revenue
Temporary License

License Number:	2010600277
Business Name:	MHM CORRECTIONAL SERVICES, INC.
Business Address:	1593 Spring Hill Road Suite 610 Vienna, VA 22182 USA

Revenue Code:	**Subtype:**	**Tax Period:**	**Business Code:**
0101	01	2010	584-PROFESSIONAL SERVICES-PSYCHOLOGY OFFICE
Receipt Date:	**Document Location Number:**	**Amount:**	**Officer:**
1/15/2010	109201517	$37.50	**(INTERNET ONE STOP LICENSE)**

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

7/1/2010

DATE (MM/DD/YYYY) 12/4/2009

PRODUCER
Lockton Companies, LLC Denver
8110 E. Union Avenue
Suite 700
Denver CO 80237
(303) 414-6000

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURED
1310906
MHM Correctional Services, Inc.
1593 Spring Hill Road, Suite 610
Vienna, VA 22182

INSURERS AFFORDING COVERAGE	NAIC #
INSURER A: Evanston Insurance Company	35378
INSURER B: Greenwich Insurance Company	22322
INSURER C: Darwin Select Insurance Company	24319
INSURER D: The Charter Oak Fire Insurance Company	25615
INSURER E:	

COVERAGES MHMCO01 EN

THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER AND THE CERTIFICATE HOLDER.

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A		GENERAL LIABILITY [X] COMMERCIAL GENERAL LIABILITY [ ] CLAIMS MADE [X] OCCUR [X] $250,000 DED GEN'L AGGREGATE LIMIT APPLIES PER: [ ] POLICY [ ] PRO-JECT [ ] LOC	MM817059	7/1/2009	7/1/2010	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 2,000,000 $ 50,000 $ Excluded $ 2,000,000 $ 6,000,000 $ 2,000,000
D		AUTOMOBILE LIABILITY [X] ANY AUTO [ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS [X] HIRED AUTOS [X] NON-OWNED AUTOS	P-810-8106C672-COF-09	8/1/2009	7/1/2010	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ XXXXXXX $ XXXXXXX $ XXXXXXX
		GARAGE LIABILITY [ ] ANY AUTO	NOT APPLICABLE			AUTO ONLY - EA ACCIDENT OTHER THAN AUTO ONLY: EA ACC AGG	$ XXXXXXX $ XXXXXXX $ XXXXXXX
C		EXCESS/UMBRELLA LIABILITY [X] OCCUR [ ] CLAIMS MADE [ ] DEDUCTIBLE [ ] UMBRELLA FORM [X] RETENTION $ 25,000	03047483	7/1/2009	7/1/2010	EACH OCCURRENCE AGGREGATE 	$ 10,000,000 $ 10,000,000 $ XXXXXXX $ XXXXXXX $ XXXXXXX
B		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? NO If yes, describe under SPECIAL PROVISIONS below	RWR9437387	8/1/2009	7/1/2010	[X] WC STATU-TORY LIMITS [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 1,000,000 $ 1,000,000 $ 1,000,000
A A		OTHER Professional Liability Claims Made	MM817059 Retro Date 12-31-00	7/1/2009 7/1/2009	7/1/2010 7/1/2010	$2,000,000: Each Claim $6,000,000: Aggregate $250,000: Deductible	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

CERTIFICATE HOLDER

10737199

James Welch
Department of Correction
245 McKee Road
Dover DE 19904

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE
Charles M. McDaniel

For questions regarding this certificate, contact the number listed in the 'Producer' section above and specify the client code 'MHMCO01'.

TAB 3. GENERAL REQUIREMENTS

MHM acknowledges, accepts, and will comply with the requirements in *Section II, B.1-3.* Because *Section II, B.1-3* does not require further response from the vendor, we have limited our response to include *Section II, B.4-24,* below, in order to consolidate information.

4. PROVISIONS OF A CONSTITUTIONAL SYSTEM FOR OFFENDER HEALTH CARE

Each Vendor must reflect in their response how their proposed service, which is one or more than one component of a constitutional system of health care delivery, will serve to reinforce the other Vendors' services, as described below:

4.I. A COMMUNICATIONS AND SICK CALL SYSTEM

1. **A Sick Call System must be provided for all offenders and must be characterized by direct communication of health care concerns between the offender and health care personnel without the opportunity for adverse security intervention;**
2. **It must be characterized by professional evaluations, including properly credentialed and trained health professionals, provided for triaging offender requests, and for attending to the serious medical needs of offenders;**
3. **Offenders in segregation have a greater need for Sick Call and must be seen every day and their health needs must be assessed by a qualified health professional.**
4. **Must use DACS Sick Call tracking and appointment system.**

MHM is bidding both the mental health and substance abuse treatment components of the RFP. Therefore, in this section, we describe our proposed approach for integrating mental health services with the overall medical sick call system.

Initial pick up and triage of sick call slips are the responsibility of the medical vendor staff. As the mental health vendor, MHM will provide training to the medical staff on the appropriate identification and referral of inmates with mental health issues. Inmates identified by the medical vendor through the sick call request process as needing mental health services will be referred to an MHM qualified mental health professional (QMHP) using the sick call slip referral process. Each day a QMHP is on-site, the sick call slips will be reviewed and the offender will be scheduled for an appointment based on the level of service necessary. Mental health sick calls will be triaged as emergent, urgent, and non-emergent (routine).

- **Emergent** – Offenders in need of immediate medical/psychiatric attention are either transferred to a specialty unit capable of providing twenty-four (24) hour observation and care or are placed on suicide/mental health watch until more suitable arrangements can be made and/or a complete mental health assessment is conducted.

- **Urgent** – Offenders who screen positive for serious mental illness are at heightened risk for suicide and/or are on psychotropic medication will receive a complete mental health assessment within one (1) working day of screening.

- **Non-emergent** – Offenders who request routine mental health services or who are identified at screening as needing a non-emergency mental health or substance abuse evaluation will receive a complete mental health assessment within ten (10) working days. .

Upon contract award, MHM will collaborate with the DDOC to ensure the triage process and criteria for designating emergent, urgent, and routine sick calls meets DDOC requirements.

4.II. PERSONNEL

1. **The system must have adequate staffing not only by plan, but in reality; (See Appendix G, Pricing for additional important information on Staffing.)**
2. **Adequate staffing must be supported by adequate resources necessary to deliver the care;**
3. **All institutions must have dedicated on-site staff.**

MHM acknowledges, accepts, and will comply with the above requirements. Our staffing plans for the mental health and substance abuse programs are provided at the end of *Tab* 5 and Tab *6, Section XI, G*, respectively.

MHM provides a centralized system of responsible and accountable management supported by operational, technological, and clinical resources. At the local and facility level, we engage experienced and credentialed staff to manage the MHM services delivery system. For this project, we will establish local program management (*Tab 2, Section III, B.1)* Delaware supported by our corporate and regional resources. All institutions will have dedicated on-site staff.

Recruiting

Maintaining full staff and low turnover rates of healthcare personnel in correctional settings (in an already competitive healthcare staffing market) is a major challenge. To meet this challenge, MHM invests heavily in the front-end recruitment resources necessary to identify and attract qualified professionals. We have an excellent record of being able to recruit and retain clinical and administrative personnel to work in challenging correctional environments. In fact, our *overall fill rate for the company's over 2,000 positions is 97%.*

MHM's Recruiting Department, comprised of a team of **12 professional healthcare recruiters**, is by far the largest in the correctional healthcare industry. Our recruiters are strategically placed throughout the country so they can support the recruitment needs of each MHM contract at a local level.

We emphasize a proactive approach, establishing candidate pools so that credentialed resources are available from which to fill newly-created and interim positions, thus minimizing the use of outside temporary staff.

MHM continually assesses staffing levels, anticipates personnel changes, and conducts recruitment activities to ensure that absences or vacancies are promptly filled. Recruiters work with professional organizations, employment agencies, and staffing firms to identify contingency candidates for unexpected or extended absences due to illness, family emergencies, or other circumstances.

Recruiters identify potential applicants for permanent and temporary positions in a variety of ways. These include:

- Purchasing physician mailing lists and sending direct mailings to qualified applicants
- Placing targeted advertisements in professional journals (print and Internet)
- Employing Internet job boards and the MHM corporate website to post positions
- Advertising in local and regional newspapers and other publications
- Posting positions with universities and residency programs
- Setting up exhibitions at association job fairs, trade shows, and conferences
- Conducting open houses and facility tours to attract candidates
- Using telemarketing (mail and telephone) locally and regionally

MHM is also applying technology to further the capabilities of our Recruiting Department. We are currently implementing a new recruiting and applicant tracking software system to enhance our ability to source, track, and maintain communication with literally thousands of healthcare professionals. Additionally, we are using technology to drive and manage an Employee Referral Program, in view of statistics confirming that this decreases time-to-hire and increases retention.

Recruiting Process:

Our core strategy for successful recruitment is based on the following progression:

1. MHM assigns a dedicated professional recruiter who is well acquainted with facility and DDOC requirements.
2. MHM staff confirms position specifications based on DDOC requirements, including credentials and qualifications.
3. Recruiters initiate a candidate search using all available resources, including MHM-customized provider databases.
4. MHM staff pre-screens candidates by surveying for specific qualifications and experience related to the position.

5. Staff members refer pre-qualified candidates to MHM's Program Manager (referred to as the Mental Health Administrator in the RFP) who schedules and conducts on-site interviews.
6. MHM staff schedule facility tours to review working conditions as well as safety and security systems.
7. Recruiters introduce prospective candidates to key facility staff with whom they will collaborate.
8. MHM recruiters confirm special candidate qualifications and consult with the Program Manager on candidate selection.
9. MHM submits selected candidates to the DDOC for security and other clearances.
10. MHM staff confirms that basic licensure prerequisites are met, in good standing, and extends offers. Primary source verification of the applicant's credentials and educational background, as well as all relevant licensure and certification, are completed during the credentialing process, which begins immediately upon employment.
11. MHM follows up with each new employee prior, during, and after their first day to ensure all questions and/or concerns are addressed.
12. Recruiters maintain a continuing relationship with the provider hire to ensure successful employment under the contract.

Improved Retention

Our best recruiting tool is the long-term retention of quality employees. We recognize that recruitment is just one component of maintaining an effective workforce. MHM considers retention and minimizing turnover to be equally important.

We strive to increase employee retention through a variety of initiatives designed to provide employees with a professionally rewarding, positive work experience. Our employment model, our continuously refined compensation and benefits packages, and our human resources systems all create a better work experience for our staff.

We support our staff by offering a competitive compensation and benefit package designed to retain valued personnel. Compensation is measured against the market through in-depth research, taking into consideration the scarcity of a specific discipline and the remoteness of a location. As employees of MHM, staff receive a benefits package that includes the following:

- Paid Life Insurance
- Medical, Dental, & Vision
- 401(k) Savings Plan
- Paid Short-Term & Long-Term Disability
- Paid CEUs
- Up to 40 Paid Days off Annually

- Paid Holidays
- Competitive Hourly Rates
- Flexible Spending Accounts
- Shift Differential
- Company-Paid Malpractice Insurance

4.III. CONTRACTING OUT

1. **The use of independent contractors does not relieve the Vendor of the legal responsibility to provide timely health care to meet the serious medical needs of offenders.**
2. **A key to Constitutional care for offenders provided by Vendors, in addition to establishing processes that meet NCCHC and other generally accepted professional standards, is the staffing of the health care delivery system with sufficient and qualified management and Vendor personnel.**

MHM acknowledges, accepts, and will comply with the above requirements. Unlike some vendors who routinely independently contract for professional staff, MHM retains staff through formal employment relationships and provides them with salaried compensation and a variety of employee benefits. Our approach not only meets IRS rules, but results in a more stable and committed workforce dedicated to our mission of client service. MHM hires only professional candidates who meet credentialing standards promulgated by national organizations, pass agency background checks, and have final approval by the agency for hire. We support our staff through orientation and training and other programs designed to create a professionally rewarding work experience (see *Tab 4, Section X, C3).*

Staffing, to include recruiting and retention, is discussed in the previous section.

4.IV. MEDICAL RECORDS

1. **Each Vendor will be responsible for maintaining the DDOC unified medical and mental health record established per DDOC policy H-01, Health Record Format & Contents.**
2. **At a minimum, records must be kept separately for each offender and include a medical history and problem list; notations of offender complaints; treatment progress notes; laboratory, x-ray, and specialists' findings, etc.**
3. **Proper medical records not only promote continuity of care and protect the health and safety of the offender population but also provide correctional administrators with evidence of the course of treatment when individual offenders sue them asserting that care was not provided.**
4. **Each Vendor must provide appropriate medical records staff.**
5. **Each Vendor must coordinate with the potential EMR Vendor to assure conversion and maintenance of the paper record to an electronic record.**

MHM acknowledges, accepts, and will comply with the above requirements as they

pertain to the mental health/substance abuse vendor. MHM staff will comply with the format and order for maintaining the DDOC's unified medical and mental health record according to DDOC policy H-01. We understand how important an up-to-date and unified health record is for the continuity of offender care and safety. We strongly support the maintenance of a unified record consistent with DDOC policy and NCCHC standards. MHM knows what it takes to complete the multiple tasks required to document mental health treatment in correctional settings.

We understand that individualized health records will be maintained for each offender and will include at least:

- Offender identifying information
- Master Problem List
- Notifications of offender complaints
- Receiving screening and health assessment documentation
- Treatment progress notes
- Orders for prescribed medications
- Medication administration records
- Laboratory reports, imaging reports and other diagnostic reports as available
- Consent and refusal forms
- Release of information authorization and related documentation
- Discharge summaries and other documentation from hospitalizations and inpatient stays when available
- Specialty consultation reports, including findings and treatment recommendations
- Special needs treatment plans
- Chronic care clinic visit documentation
- Immunization records and communicable disease history and testing
- Infirmary care records or summary of infirmary care

All mental health contacts and significant non-contact developments related to mental health will be documented in the offender's record.

We understand that the health record is to be readily available and used during health encounters. It is MHM's experience that the quality of care is substantially enhanced when the record is available during mental health encounters. When the record is not available or current, treatment decisions cannot be informed by the offender's prior history and significant risks are incurred. MHM will collaborate closely with the medical vendor to ensure the health record is available to staff for treatment encounters and that documentation of mental health services is filed promptly in the record.

Mental health progress notes will follow the SOAP format. MHM has developed staff training to support staff in completing thorough SOAP notes that link the encounter, intervention, and offender's response back to the offender's treatment plan. Upon request, we can offer the DDOC examples of SOAP note templates that contain specific prompts to ensure comprehensive documentation. We have developed these templates for psychiatric providers working in outpatient settings, psychiatric providers working in inpatient/mental

health unit settings, and psychiatric nursing staff working in inpatient settings. These templates are the product of CQI studies conducted in other correctional systems and they have been part of the solution when the quality of documentation has needed to be improved.

Clarity in the course of treatment, as reflected in the mental health record, is one of the foundations for appropriate care and treatment. MHM understands that mental health documentation constitutes a record of service delivery and that the integrity of this record is essential to being able to demonstrate that constitutionally required treatment has been provided. We have extensive experience assisting clients in addressing court consent agreements, Memoranda of Agreement developed by the Department of Justice, and standards established by accreditation agencies such as the NCCHC. Accurate and thorough documentation of service delivery is essential to meeting these goals and, as noted in the RFP, defending against individual lawsuits brought by offenders who allege that care was not provided.

Clerical Staff/EMR

MHM's clerical staff will provide support in maintaining offender health records; however, we assume that the medical services vendor will have primary responsibility for offender health records. If the DDOC develops or acquires an electronic medical record (EMR), MHM will collaborate with the EMR vendor to ensure continuity of paper and electronic records during the transition to an electronic format. We have experience utilizing EMRs in several existing correctional systems and will be available to assist the DDOC in considering options for an EMR if requested.

4.V OUTSIDE CARE

1. **Offenders requiring a specialist evaluation, a sophisticated diagnostic test, or offender care that is not available in the DDOC facility, must be provided timely access to these services in the community; therefore, a system must be in place to schedule and facilitate off-site appointments for needed care that is coordinated through the facilities security transportation staff.**
2. **The use of Telemedicine or on-site specialty care rather than off-site care must be developed through purchase and maintenance of equipment.**
3. **Each Vendor's staff must use the DACS consult tracking.**
4. **Each Vendor will make all reasonable efforts to provide services at the facilities so as to minimize the inherent risk to the public related to the movement of offenders outside of the correctional environment.**

MHM acknowledges, accepts, and will comply with the above requirements. It is MHM's experience that outside specialty consultations for mental health purposes are rare. When specialized mental health care is needed and not currently available on site, MHM offers Clinical Operations specialists to provide consultative evaluations and/or treatment. In the rare event that an outside mental health consultation is needed, MHM staff will utilize the DACS consult tracking system.

MHM understands that DDOC offenders are occasionally subject to civil commitment to the state psychiatric hospital for involuntary treatment or inpatient care. We assume that these commitments take place with the coordination of facility administration and security staff, including the transportation office. Additionally, mental health caseload offenders may require emergent medical care for self-inflicted injuries that cannot be safely treated on site. In all cases, MHM will collaborate with facility administration and security staff to ensure transportation is coordinated appropriately.

Telepsychiatry Equipment

MHM understands that the use of telepsychiatry or onsite specialty care, rather than offsite care, will require MHM to purchase and maintain any necessary equipment. There are numerous options for establishing remote televideo connections. These range from high-end telemedicine suites that utilize dedicated fiber-optic connections between locations to transmit images (including endoscopic images) and audio of the highest quality to low cost, web-based applications that are sufficient for psychiatry services. The portability of web-based systems and improvements in image quality have greatly expanded the capabilities for using telepsychiatry in prisons where offender transport is an issue.

We are currently having great success using desktop and laptop computers for telepsychiatry services that can be utilized virtually anywhere in a prison setting to link offenders with psychiatrists. We have even been successful using wireless computer communication technology to connect remote housing units to outside psychiatrists and mobile psychiatrists to prison facilities.

For further information regarding telepsychiatry, see *Tab 5, Section IV, u.*

4.VI. Facilities and Resources

1. Vendor must ensure that the space and supplies be adequately maintained to meet the health care needs of the institutional population. Dangerous or unsanitary physical equipment or unavailability of medications or other items such as eyeglasses, dentures, braces, or prostheses can lead to violations of the Constitution. Vendor(s) are responsible for equipment under $500.

This is the responsibility of the medical vendor. However, MHM acknowledges that we are responsible for telepsychiatry equipment, as mentioned previously. All space used by MHM staff will be adequately maintained.

4.VII. Quality Improvement, Accreditation, & Compliance with Standards

1. **Quality improvement is a process of ongoing monitoring and evaluation to assess the adequacy and appropriateness of the care provided and to institute corrective action as needed;**

2. **Each Vendor under this solicitation is required to have its own Continuous Quality Improvement System (CQIS) to assure the adequacy and appropriateness of care provided, and for reporting on this monthly to the DDOC according to DDOC policy.**
3. **Each Vendor shall provide a written CQIS plan which assures that offenders receive medically necessary care with quality equivalent to that provided in the generally accepted professional standards across all areas of service provided under this contract. This must be done while accommodating security concerns. The Vendor must work closely with the DDOC to assure that health care and security needs are met for all levels of offenders at all times.**
4. **Each Vendor's CQIS shall include such audits, narrative reports and executive summaries necessary to identify and remedy any quality issues identified in the Vendor's operations and consistent with, and/or required by the DDOC.**
5. **Reports of activity from the monthly meetings distributed on CQIS affecting services provided pursuant to this contract must be provided to the DDOC Chief, Bureau of Correctional Healthcare Services ("BCHS") (or designee) (collectively herein "Bureau Chief") on a monthly basis. Any reports provided under contractual obligation will remain confidential unless otherwise authorized by BCHS, however, all documents related to offender care and quality improvement activities must remain available to the DDOC at all times.**
6. **All reports, data compilations, and other information submissions required by the contract shall be certified by the Vendor's appropriate supervisory employee.**
7. **Each Vendor will provide Quality Assurance, QA Metrics for BCHS monitoring of the healthcare system as stipulated by BCHS. The QA Metrics will include clinical, fiscal, operational, and other data to facilitate comprehensive monitoring of the healthcare system. Examples of the QA Metrics that will be required will be found in the QA Metrics Appendix D. The vendor should be aware that a failure to meet the standards set forth in the QA matrix may result in a financial penalty or other off-set.**
8. **Clinical staff will participate in the peer review program administered by BCHS. Vendors will participate in ensuring that clinical staff move forward on any corrective action plan developed to correct deficiencies identified by the peer review process, random or scheduled audits or other processes. Medical Providers will receive privileges to practice in the DDOC healthcare system based on credentialing and maintenance of performance as judged by the peer review system. Providers may have privileges revoked at any time due to failure to correct performance deficiencies identified through peer review or other means or because of egregious breaches of conduct or clinical performance as judged by BCHS.**

Continuous Quality Improvement

MHM acknowledges, accepts, and will comply with the above requirements. MHM is committed to ensuring implementation of a strong quality improvement process.
In current contracts, we cooperate with in the implementation of the client's Continuous Quality Improvement (CQI) program as well as the CQI program of the medical

provider. We are an active member of the CQI programs conducted system-wide and at each facility and collect all information and statistics requested.

MHM also conducts an internal CQI program to complement the client's and medical provider's CQI programs. The MHM internal CQI program offers a forum in which mental health issues are the primary focus. MHM believes that mental health services are improved through an ongoing examination of processes, procedures and data by a multidisciplinary team of staff who perform the services.

MHM has developed a Model CQI program that is consistent with NCCHC standards and is tailored to the unique requirements of the client. The MHM Model CQI program includes the structure of the CQI Committee, the types of studies to be conducted and an annual peer review process for all licensed clinicians. The peer review process includes audit tools for each discipline and forms for notification of staff and the client about the peer reviews conducted. The audit tools are reviewed annually and revised to reflect current concerns and system changes.

We are confident that the MHM CQI program will comply with the DDOC requirement that each vendor have its own Continuous Quality Improvement System (CQIS) to assure the adequacy and appropriateness of care provided.

CQI monitoring evaluates the following quality indicators:

- **Timeliness:** whether the care or intervention is provided to the offender at the most beneficial or necessary time
- **Effectiveness:** whether a particular intervention results in the desired outcome
- **Appropriateness:** whether the care or intervention provided is relevant to the offender's clinical needs and community standards of care
- **Continuity:** whether that care or intervention is coordinated among practitioners, between institutions, and across time
- **Quality of provider and offender relationship:** the degree that the offender is involved in care decisions and the degree of sensitivity and respect shown by the service provider for the offender's differing needs and expectations

Quality of care issues addressed by the MHM CQI program include the following:

- Timeliness and quality of intake screenings and mental health assessments when an offender is admitted to the facility
- Mental health services are provided for offenders of all security levels
- Mental health staff response to offender requests for assistance
- Timeliness and quality of crisis interventions
- Psychiatric and mental health staff follow-up with offenders who have serious mental illness

- Individualized and updated treatment plans for special needs offenders with progress notes indicating progress or lack of progress toward identified goals
- Documentation of an offender's mental health level, problem lists, and current level of functioning
- Documentation of psychotropic medication informed consent, appropriate laboratory testing and monitoring, and AIMS monitoring
- Psychiatry and counseling progress notes: offenders seen within required timeframes, notes related to treatment plan, target symptoms identified, and reflective of continuity of care
- Medication administration practices
- Psychotropic medication compliance monitoring
- Psychotropic medication use and related medical monitoring
- Appropriate initial and continuing mental health caseload placement
- Appropriate mental health unit admissions and discharges
- Review of offenders requiring repeated/frequent crisis interventions and/or emergency admission to a mental health unit
- Discharge planning
- Consistency, quality, and participation in group programming
- Trends in incidences of offender self-harm and the interventions used
- Mental health consultation to the disciplinary process
- Mental health rounds of segregation units
- Review of mental health staffs' credentials and current licensure
- Provision of mental health training to facility staff
- Adequacy of mental health staffing to meet the mental health needs of specific facility

Monitoring/Auditing

MHM's Clinical Operations Department, under the direction of Dr. Jane Haddad, develops a unique contract compliance monitoring and auditing tool for each MHM contract. This tool incorporates the requirements of the client's original procurement document (RFP), MHM's proposal, the policies and procedures of the client agency (DDOC), the actual contract document, pending court actions related to mental health services, and any applicable accreditation standards such as NCCHC and ACA. Our Clinical Operations Department uses this to conduct annual internal audits of each MHM contract.

The findings of the audit are documented and shared with the client agency. These findings are used to develop action plans to correct any deficiencies and to identify any clinical programming needs.

Monitoring (including auditing) is critical to maintain high levels of care and contract compliance. Therefore, MHM monitors our programs on every level using our corporate, regional, and local resources. These monitoring systems are currently utilized across all of our contracts.

Our Clinical Operations Department performs contract compliance audits of our

facilities. Coming from a corporate level, this department acts autonomously and independently from each program. It does not audit from a financial standpoint (in terms of MHM's own budgets), but rather from a *clinical perspective,* ensuring that we are meeting the requirements of our contracts and the needs of the populations we serve.

To perform a contract audit, the Clinical Operations Department spends several days on site – interviewing staff (including administration and security staff) and offenders. They review records and policies, provide staff training, and give a comprehensive exit summary documenting action plans and recommendations. These results are then shared with the client. MHM acts on all findings.

Team members from the Clinical Operations Department often remain involved with the program, post-audit, to help implement new programming and treatment modules and staff training.

Regionally, our Program Managers oversee contract monitoring audits as well, similar to those performed by our Clinical Operations Department.

Contract Compliance Audits have identified "best practices" and treatment efficiencies within particular contracts. These practices have been shared across other correctional systems, resulting in synergistic quality improvement.

Through our layered process of monitoring, MHM staff gain a thorough knowledge of what is happening in each program. This stimulates a quicker response to any recommended changes, and ensures a high level of quality that is likely to yield successful results from any external audit.

Monitoring is further enhanced by incorporating peer reviews among local staff. Our clerical staff monitor the peer review process to ensure that we are meeting timeframes and following documentation guidelines.

Furthermore, prescribing patterns are monitored and compared to national averages through our Pharmacy Management Program (see *Tab 2, Section III, B.1*).

CQI Committee/Action Plans

The primary purpose of the MHM CQI Committee is to identify problems and opportunities for improvement based upon the data collected in the monitoring process, including offender grievances. As part of the program, a major occurrence report is initiated for completed suicides, serious suicide attempts that require off-site or infirmary medical care, and deaths of offenders receiving mental health unit services. Results of the CQI activities are analyzed to generate recommendations for corrective actions. Action plans based on the recommendations are implemented and routinely monitored to assess the effectiveness of the corrective action to improve the mental health service delivery system. If one corrective action plan does not result in the intended improvement, an alternative action plan is developed, implemented, and monitored.

Findings and recommendations from the MHM CQI program are regularly shared with the other CQI programs of the system. We will ensure that utilization and outcome data as well as the results of CQI studies and corrective action plans are reported to the DDOC BCHS monthly according to DDOC policy.

Peer Review

As noted previously, MHM's CQI program includes an annual peer review process for all licensed disciplines. MHM understands that the DDOC requires quarterly peer review of medical staff as defined by the BCHS. We also understand that clinical staff will be permitted by the BCHS to practice within the DDOC based upon initial credentialing and maintenance of performance as judged by the peer review system. If a performance deficiency is identified by the peer review process or other processes, a clinician must successfully complete a corrective action plan to retain privileging. Serious breaches of conduct or clinical performance will result in dismissal. MHM fully supports the DDOC BCHS' efforts to ensure clinically appropriate mental health services. Our staff will comply with the expectations of the DDOC peer review process.

Upon contract award, MHM's Clinical Operations Department will meet with the DDOC BCHS to ensure that the CQIS program developed by MHM meets all the BCHS requirements related to clinical, fiscal, operational, peer review and other areas required to facilitate comprehensive monitoring of the mental health delivery system. We understand that failure to meet the DDOC standards may result in a financial penalty or other off-set.

5. Special Accommodation Populations

The DDOC has many offenders who have special health care needs. Medical and Mental Health services must adjust to provide services identified in the individualized treatment care plans. Each Vendor providing clinical staff shall require them to provide Case Management services to assure that there is no discontinuity in their care and to assure that the plan of care is designed to produce the most positive outcomes. The following groups must be case managed in order to accommodate their special needs:

i. **Disabled Offenders**
ii. **Elderly Offenders**
iii. **Chronically Ill Offenders**
iv. **Mentally Ill Offenders**
v. **Offenders in a Diagnostic or Therapeutic "Pipeline"**

iv. Mentally Ill Offenders

Offenders who have an active mental illness and, especially, offenders who have had an exacerbation of their mental illness, are newly diagnosed, unstable on medication or difficult to treat, or whose status has otherwise decompensated such that a more intense level of care is required, must be actively treated and closely monitored. This includes offenders placed on suicide precautions and offenders

who have made suicide attempts. The Vendor must also identify those with serious mental illness using DACS.

MHM acknowledges, accepts, and will comply with the above requirements.

As the national leading provider of correctional mental health services, MHM will bring the latest advances in correctional mental health care to the Delaware prison system to improve the quality, efficiency, and scope of the overall mental health program.

We are fully aware of the presence of offenders with special accommodation needs within correctional settings and have experience working with these populations as well as special treatment programs and services for this population. Often, offenders who are disabled, elderly, or chronically ill have overlapping mental health and substance abuse treatment needs making them highly complex cases from a medical/mental health perspective. Successful management of these inmates requires a collaborative effort between medical and mental health staff. We work closely alongside medical vendors in each of our nine state correctional mental health programs and routinely jointly manage the overall care for complex offenders with the medical vendor.

We will provide mental health services as identified in an offender's individualized treatment plan. MHM specializes in providing constitutionally required treatment for mentally ill offenders in multiple correctional systems. We have unparalleled treatment protocols and processes for ensuring that offenders who need mental health treatment receive it. MHM's mental health services have been developed from our core expertise in this area, and our specialized focus in this area ensures that treatment of mentally ill offenders is not an after-thought or secondary consideration in the provision of offender care.

MHM mental health treatment services include the following:

- Mental health screening and evaluation of offenders at reception
- Offender orientation to the mental health services available
- Consultation with administrative and security staff for offenders with special needs
- Psychiatric evaluation and follow-up as clinically indicated, including monitoring offenders for treatment responses and side effects
- Timely response to offender sick call requests and staff referrals for mental health assistance
- Crisis interventions, including placement of offenders on watch
- 24/7 on-call psychiatric consultation services
- Treatment planning and review for offenders receiving ongoing mental health services
- No less than monthly follow-up of offenders receiving ongoing mental health services
- Structured psychoeducational and psychotherapeutic group programming
- Follow-up of offender treatment and medication noncompliance

- Mental health services for offenders housed in segregation units
- Discharge planning in coordination with classification and medical staff

As described in *Tabs 4* and *5*, MHM staff will also provide specialized treatment in substance abuse and in sex offender treatment.

All MHM staff are trained in suicide prevention and in the recognition of clinically unstable and high risk clinical presentations that require a more intense level of care and monitoring. We approach offender safety and treatment needs conservatively to avoid unnecessary risks. The levels of intervention provided for offenders are increased to match increased risk and increased treatment needs when these arise. This is part of the risk-need-responsivity paradigm described elsewhere in the proposal.

We have extensive protocols for placing offenders on mental health watch due to psychiatric decompensation, behavioral instability, or suicide risk. Our protocols include the development of crisis treatment plans, ongoing monitoring and documentation, reduction of intrusive interventions as soon as it is safe to do so, and graduated step-downs of offenders who have required watch or other intensified treatments. Our staff conduct offender debriefings and review the offender's treatment plan in response to crisis interventions. The goal is to utilize proactive treatment interventions to minimize the likelihood of a recurrence of the crisis. We will follow all NCCHC standards and DDOC policies and procedures related to these practices. Upon request, MHM can provide Clinical Operations consultation to assist in strengthening crisis intervention protocols.

MHM will follow all DDOC policies and NCCHC standards in providing Case Management services to offenders receiving mental health treatment. We will ensure that offenders with special mental health treatment needs receive effective Case Management services. Treatment and discharge planning will be conducted according to DDOC protocols, including the utilization of DACS. All offenders who have serious mental illness will be identified as such in DACS.

Case Management services address but are not limited to the following areas for caseload offenders:

- Amelioration of symptoms of serious mental illness
- Amelioration of adjustment difficulties, including those that require supportive and skills-building treatment
- Support for psychiatric and behavioral stability, including provision of mental health interventions that guard against decompensation
- Reduction of aggressive behavior and homicidal ideation
- Treatment and management of exposure to trauma or victimization
- Reduction of suicidal and self-injurious ideation and behavior
- In collaboration with medical staff, management of psychiatric and behavioral components of dementia
- Mental health support and planning for offenders with developmental or intellectual disabilities

As discussed in detail elsewhere in this proposal, MHM has developed extensive policies, procedures, treatment guidelines, individual and group programming, and specialized protocols that can be utilized to guide Case Management decisions.

6. Special Needs Populations

i) Special Needs offenders will be defined as those offenders with complicated medical issues that are exacerbated by mental health issues (or co-occurring disease) or those offenders with complicated mental health pictures that lead to or have the potential to lead to medical involvement (multiple PCO admissions, cutting or other self injurious behaviors, etc.)

ii) The Vendor will participate in multidisciplinary team meetings to discuss treatment and management of these offenders. These team meetings will identify objective and measurable entry criteria for enrollment on the special needs roster and will identify objective measures of treatment progress and will identify exit criteria based on accomplishment of progress along the treatment plan.

MHM acknowledges, accepts, and will comply with the above requirements. We understand that Special Needs offenders include but are not limited to:

- Offenders with complicated medical issues that are exacerbated by mental health issues or co-occurring disease
- Offenders with complicated mental health issues that may lead to medical involvement such as multiple PCO admissions, cutting, or other self-injurious behaviors

MHM welcomes the opportunity to participate in multidisciplinary team meetings to discuss the treatment and management of these offenders. Our experience is that without such multidisciplinary collaboration, treatment for Special Needs offenders is often ineffective and may result in an increase, rather than a decrease, of offender treatment needs. We have extensive experience working with medical, mental health, security, and administrative staff to develop objective, proactive treatment plans that address complex treatment needs. Typically, when an offender has Special Needs as defined above, staff from all providers are involved in the offender's care and custody. The treatment and management of Special Needs offenders requires all staff and disciplines to provide services in a consistent and planned manner. Regularly scheduled multidisciplinary treatment team meetings are the best venue for developing an integrated plan that ensures consistent and effective treatment.

Our experience confirms that offenders with severe mental illness and significant medical needs often require extra assistance in achieving and maintaining compliance with medical care. Some offenders may not be able to advocate for themselves as needed while others may not be able to identify and communicate physical signs and symptoms accurately.

Offenders with depression may be unmotivated to seek medical care when it is needed, and offenders with psychosis may not be able to make informed medical decisions or recognize their treatment needs. We conduct assessments of offenders' medical decision-making abilities, but our multidisciplinary collaboration goes beyond assessment. We utilize the DSM-IV-TR multi-axial diagnostic system to ensure that all healthcare staff are aware of offenders' treatment needs on Axes I, II, and III; and we provide interventions to support offenders' medical care.

Behavior Management

Another segment of the Special Needs population that requires particularly careful multidisciplinary planning includes offenders who require inpatient levels of treatment due to self-injurious and other extreme maladaptive behaviors. Frequently in correctional systems, a small group of offenders with recurrent and severe self-injurious behaviors taxes mental health, medical, and security staff. In our experience, these offenders have repeatedly required treatment within licensed or inpatient mental health settings as a result of the severity of their behavior. Often, they have high levels of behavioral impulsivity, anger, alienation, and determination; and they are at high risk for suicide or accidental death. They typically have long segregation sentences due to disciplinary infractions and severe Axis II pathology. Some may also have serious mental illness that contributes to their behavior. We understand just how risky, challenging, and resource-intensive these offender behaviors can be.

To meet the needs of this high-intensity offender group, MHM has developed a company-wide behavior management program. This program includes functional assessment of problem behaviors; intensive risk assessment; multidisciplinary collaboration and treatment planning; and multiple interventions including pharmacotherapy, psychoeducational programming, and cognitive-behavioral interventions to reduce and eventually eliminate maladaptive behaviors.

MHM's behavior management interventions are supported by a thorough clinical infrastructure. Detailed policy and procedures have been developed to guide interventions, support offender autonomy and rights, and avoid abusive or punitive responses to problem behaviors. We have a library of behavior management templates and strategies that we make available to our clients. Guidelines for multidisciplinary collaboration include mental health, medical, and security staff as well as facility administration. We ensure that self-injurious offenders receive prompt emergency medical care as clinically indicated; however, we strive to provide this care in a manner that minimizes "secondary gain" and the inadvertent reinforcement of the problem behavior.

MHM's behavioral management initiatives include more than rewarding offenders for the absence of unwanted behaviors. All too often, behaviorally disturbed offenders are simply expected to stop unwanted behaviors with the promise of a reward after a set amount of time. For many offenders, such expectations are unrealistic. MHM utilizes empirically supported cognitive-behavioral interventions to build desired skills in this

population. We have also developed in-cell psychoeducational programming and structured group curricula to engage self-injurious offenders in developing a menu of replacement behaviors. Many of the interventions developed within Dialectical Behavior Therapy (a cognitive-behavioral model for addressing self-injurious behavior created by Marsha Linehan) are included in this programming.

MHM has developed staff training modules in de-escalation and behavioral interventions, conducting functional assessments, ethical guidelines in behavior management, and working with staff. This training has been tested and found effective in multiple correctional settings. Day-long behavior management workshops have been provided to multidisciplinary staff working in secure, licensed, inpatient mental health settings. MHM includes security staff in its training sessions to ensure consistency in approach and collaborative communication across disciplines. Our experience is that safety cannot be assured unless correctional officers are included in the multidisciplinary treatment team and in unified approaches to behavioral disturbances.

While the goal of MHM's clinical infrastructure is to develop local behavioral expertise within every correctional system, a team of nationally recognized behavioral consultants is also available through MHM's Clinical Operations Department. These consultants provide functional risk assessments and behavioral planning assistance for high-risk, high-profile, "treatment resistant" offenders. To date, such behavioral consultations have been provided in state correctional systems in Alabama, Florida, Maryland, Massachusetts, Pennsylvania, and Tennessee.

In developing behavior management plans, behavioral specialists work closely with psychiatric staff to ensure that pharmacological interventions are not overlooked or overused. Psychotropic medications often temper behavioral impulsivity and emotional reactivity and can assist offenders in maintaining behavioral control. However, offenders may engage in self-injury in an attempt to access preferred medications and/or as part of a larger pattern of exaggerating or feigning mental illness. MHM clinical leadership has extensive experience with the assessment of mental illness and the determination of treatment needs. A 25-module staff training series supports accurate diagnoses in a correctional setting.

In addition to psychotropic management, offenders with severe behavioral disturbances sometimes require emergency interventions to restore safety. The use of PRN psychotropic medication is discouraged in an effort to avoid polypharmacy and/or the reliance on medicine in lieu of self-regulation skills. However, emergency medications are provided when clinically indicated. Proactive planning and collaboration with medical and security staff in the event the offender requires emergency medical care is a part of our behavior management program.

While the goal is always to utilize the least restrictive intervention required to restore and maintain safety, intrusive interventions may be needed to prevent serious harm. MHM provides comprehensive training to credentialed staff in the use and monitoring of therapeutic restraints. We routinely monitor instances of crisis interventions (mental

health watches, emergency involuntary medications, and therapeutic restraints) through our CQI program and annual contract compliance audits. Our monitoring ensures that the least restrictive interventions are utilized for the shortest possible duration and that quality documentation supports the crisis intervention.

In the last year, MHM has developed a tracking system to monitor the effectiveness of behavioral interventions in reducing the frequency and severity of maladaptive behaviors. Anecdotal evidence strongly supports the use of these interventions with objective outcome data currently being gathered across multiple sites.

Other Special Needs Populations

Additional special needs populations include offenders with co-occurring medical and psychiatric disorders and/or chronic illnesses, such as:

- Hypertension
- Diabetes
- HIV
- Seizure disorders
- Pregnant offenders
- Offenders with orthoses, prostheses, and other physical aids to impairment.

Delivering services to this population requires close collaboration between the medical and mental health personnel. Our staff will routinely consult with medical staff on the overall treatment needs of offenders with special needs.

According to NCCHC criteria, other special needs populations include offenders with serious mental health needs such as basic psychotic or mood disorders. MHM treats and manages this population routinely, and we have incorporated our treatment approach throughout this proposal.

7. HIV/AIDS Screening, Testing and Treatment

i) The Vendor will provide HIV testing to all offenders within one week of intake. Offenders will receive HIV pretest and post test counseling. Offenders may refused to be tested based on the principle of "opt out" (an offender must refuse the test in order for the test not to occur automatically after pretest counseling has been given, instead of an "opt in" model where the offender must request or meet screening/risk qualifications for the test). Offenders have a right to refuse testing. The Vendor will use the laboratory and forms provided by the DDOC for HIV testing and utilize the Delaware Public Health Laboratory for such testing. The Vendor providing medical services is responsible for reporting all communicable diseases, including HIV/AIDS, to the BCHS and the Division of Public Health according to State law…

HIV screening, testing, and treatment is the responsibility of the medical vendor. As

described in the previous section, our staff will routinely consult with medical staff on the overall treatment needs of offenders with co-occurring medical and psychiatric disorders, including offenders with HIV.

8. Emergency Services & Maintenance of Automatic Electronic Defibrillators

i) Each Vendor is responsible for assuring adequate response to medical emergencies consistent with NCCHC Standards and DDOC policy.

ii) Each Vendor will use and maintain the DDOC's Automatic Electronic Defibrillators (AEDs) in each institution and facility in cooperation with the DDOC. The Vendor providing medical services will provide appropriate training in AED use and CPR training to all DDOC correctional staff, including Correctional Employee Initial Training (CEIT) classes. At least one person per shift must be certified on the use of AEDs as well as CPR. The Vendor providing medical services will ensure appropriate follow-up procedures and medication protocols are administered.

All MHM staff will support adequate responses to medical emergencies for offenders and staff. We will meet NCCHC and DDOC standards in providing and/or supporting emergency medical care. MHM staff are trained to recognize signs of medical emergencies, either in the context of diagnosing delirium; monitoring offenders in therapeutic restraints for signs of respiratory distress; monitoring offenders for polydispsia and hyponatremia; recognizing signs and symptoms of life-threatening intoxication and withdrawal symptoms; or responding to suicide attempts.

While not all MHM staff are medically trained, all MHM staff will maintain current certification in CPR and AED use. Upon contract award, we will develop a schedule in collaboration with the DDOC for our staff to be certified in CPR and AED use. Mental health staff will be trained to respond to medical emergencies and to participate in life-saving interventions. Our staff are trained not to provide services outside the scope of their practice, to alert medical providers to any medical emergencies, and to refer medical concerns to the medical services vendor. We understand that the medical services vendor will be responsible for ensuring that necessary medical procedures and medication protocols are completed following a medical emergency.

9. Suicide Prevention

Each Vendor will assure the DDOC BCHS suicide prevention procedures are followed by all health care staff. The Vendor's suicide prevention policy, procedures, and practices shall be consistent with DDOC Policy G-05, Suicide Prevention, Policies and Procedures. The Vendor awarded the contract for mental health services shall provide all mental health related training, to include suicide prevention, in accordance with DDOC policy.

MHM acknowledges, accepts, and will comply with the above requirements. We fully appreciate the suicide risks that accompany the offender population, and our staff are focused on identifying and reducing suicide risk. We discuss suicide prevention at length in *Tab 5, Section IV, f.*

10. STANDARDS

DDOC recognizes that standards of care are dynamic, constantly evolving, and not readily defined by a single authority. Therefore, for the purposes of this RFP, the currently accepted standards of care are defined by the multiple sources in the following list. The Vendor providing on-site medical services shall assure that a medical staff member at each site shall serve as the site medical authority and shall make decisions based on the Vendor's clinical protocols established by the Vendor consistent with these standards and accepted by the DDOC during the course of contracting for services under this RFP. If a Vendor uses standards different from those in the following list, they must be highlighted in the Vendor's response along with the reasons for using the standards. In addition, they must be approved by the Bureau Chief prior to use by the Vendor. The Bureau Chief must approve any change in the use of standards during the course of the contract resulting from this solicitation.

DDOC also recognizes that all clinical situations may not be covered in existing standards, and, in such cases, the proper course of action must be determined in conjunction with the DDOC BCHS.

This list of professional regulations and guidelines is intended to be indicative of the generally accepted professional standard of care and, therefore, is not all-inclusive:

- **DDOC Health Care Policies;**
- **NCCHC Standards**
- **Vendor Policies, Procedures, Guidelines and Protocols accepted by DDOC;**
- **Centers for Disease Control Protocols and Guidelines as determined applicable by the DDOC;**
- **Federal OSHA Guidelines;**
- **US Public Health Service Task Force on Preventive Guidelines;**
- **Other DDOC recognized authorities such as the Federal Bureau of Prisons, American Diabetes Association, American Medical Association, the National Commission on Correctional Health Care, American Correctional Association, and other nationally recognized professional health care organizations.**

MHM acknowledges, accepts, and will comply with the above requirements as they pertain to mental health and substance abuse. We will ensure that our staff provide services that comply with prevailing ethical and professional standards and the rules, procedures, and regulations mentioned above. As noted previously, MHM's Clinical Operations Department develops a unique contract compliance monitoring and auditing tool for each MHM contract. This tool incorporates requirements specific to the contract

as well as the accreditation standards of the NCCHC and ACA. The Clinical Operations team uses this audit tool to conduct annual internal reviews of each MHM contract.

The findings of the review are documented and shared with the client. These findings are used to develop action plans to correct any deficiencies and to identify clinical programming needs.

11. RESEARCH

No research projects involving offenders (other than projects requiring limited information from records compiled in the ordinary delivery of services) will be conducted without the prior written consent of the Commissioner of Correction. The conditions under which the research will be conducted will be governed by written guidelines mutually agreeable to by the vendor and the DDOC. In every case, the written informed consent of each offender who is a subject of the research project will be obtained prior to the offender's participation. All Federal and State regulations applicable to such research will be fully and strictly followed, including but not limited to HIPAA regulations. Research must be approved by a Human Subjects Review Board approved by the Bureau Chief.

MHM understands the DDOC's requirements for conducting research with offenders. We have no plans to conduct such research. If requested by the DDOC, we will collaborate in conducting research under the DDOC's direction. We understand that such research would be guided by prior written consent from the Commissioner of Corrections, by written guidelines developed and agreed to by MHM and the DDOC, by applicable Federal and State regulations, and by approval of a Human Subjects Review Board. Through our Clinical Operations Department, MHM has the capability of designing rigorous research studies with testable hypotheses, providing sophisticated statistical analyses of the data, and developing practical applications from the results. These capabilities will be made available to the DDOC upon request.

As discussed elsewhere in this proposal, MHM does regularly collect program evaluation data. These data are necessary to assess the efficacy of our treatment protocols; and we are currently assessing the efficacy of our group treatment modules, our in-cell psychoeducational modules for long-term segregation offenders, and our behavior management interventions. These data are collected from records compiled in the ordinary delivery of services, and our data collection project does not constitute research with human participants. Our primary focus is providing empirically-supported treatment to offenders.

12. DRUG FREE WORKPLACE

The Vendor is to have a drug-free work place with sufficient policies to comply with Federal and State regulations and DDOC policies. The Vendor will be required to maintain and develop a urine analysis program for all employees, comparable to the DDOC's random urine analysis program. The DDOC reserves

the right to review urine analysis procedures and results. The Vendor agrees to comply with any current or future drug detection initiative that the DDOC may implement applicable to vendor employees, visitors and consultants.

MHM is committed to a drug free workplace and acknowledges, accepts, and will comply with the above requirements.

13. VENDOR EMPLOYEE ORIENTATION

The Vendor will describe in detail the personnel orientation program and provide copies of the outlines or manuals in the appendix of its proposal. The Vendor will be responsible for ensuring that all new personnel are properly cleared for entry into the facility and provided with orientation and appropriate training regarding medical practices and security. Orientation regarding other institutional operations will be the responsibility of the DDOC. The Vendor will ensure that all newly hired, full-time health care personnel receive 40 hours of pre-service training and orienting within the first 30 days of employment. Orientation refers to that training necessary to ensure the employee's ability to perform the tasks associated with his/her position and to familiarizing the employee with the specific institution(s) he/she is assigned to and the Vendor's responsibilities, policies, and procedures at that (those) institution(s).

At a minimum, Vendor employee orientation will address DDOC security, DDOC code of ethics, code of conduct, drug free workplace, blood borne pathogen policies, and Vendor policies and procedures.

Vendor employee orientation will include a security orientation with DDOC staff. The Vendor will require all personnel to attend security orientation refresher training when the DDOC offers it. This training may include DDOC-wide policies and procedures and be tailored to meet the conditions of each institution...

MHM acknowledges, accepts, and will comply with the *Vendor Employee Orientation* requirements as they pertain to the mental health/substance abuse vendor. MHM is proud of the comprehensive orientation program that has been developed for new MHM staff. This orientation includes numerous modules, some that are required prior to new staff assuming job responsibilities and others that are to be completed within the first 30 days of employment. The MHM New Employee Orientation Program will be complemented by the security training offered by the DDOC.

Each of the New Employee Orientation modules has been developed in a format that permits group or individual presentation. Content is presented in CDs of PowerPoint presentations with relevant handouts. If PowerPoint equipment is not available, the presentation is completed by printing out the PowerPoint slides. This facilitates implementation with a small group of new employees. Post-tests are provided for clinical areas of the orientation to assess the new employee's understanding of the

concepts presented.

An overview of the topics presented in the New Employee Orientation Program follows. A copy of the clinical components of this program is provided in **Attachment C.** Upon contract award, MHM staff will review our New Employee Orientation Program with the DDOC BCHS and make any recommended revisions to ensure full compliance with DDOC expectations, particularly with the modules developed for the DDOC to address the "Structure of Specific Contract" modules. We appreciate that the DDOC must approve the New Employee Orientation Program prior to implementation.

Overview of MHM's New Employee Orientation Program

MHM's new employee orientation program covers the following general topics:

MHM Human Resources Orientation

- MHM Corporate organization
- Regional Office organization
- Employee Handbook review – ethical requirements and standards of conduct
- Credentialing requirements and job descriptions
- Sexual harassment policy
- Drug-free environment
- Benefits overview
- Accident injury reporting
- Kronos time procedures
- Leave policy
- PDO request processing
- Travel expense reporting
- Performance evaluations
- Corrective action process
- Staff meetings
- Staff in-services
- Continuing education opportunities
- Continuing education requests and payment
- CEU training documentation
- Employee satisfaction surveys
- Business equipment: beepers, blackberries, business cards, signature stamp
- Answering service for after-hours calls (if applicable)

Introduction to Correctional Healthcare

- Introduction to Corrections
  - Corrections overview - security; differences between public sector patients and offender populations; offender rights
  - Overview of correctional staff structure

  - Basic security practices - security as prime directive; identification card; signing in and out of the facility; key control; contraband policy; parking; security procedures for communication and emergencies; telephone access

- Boundaries and Safe Practices
  - Importance of maintaining appropriate boundaries with offenders
  - Practices that will maintain staff safety

General Healthcare Requirements

- Infection Control
- OSHA Blood borne Pathogens - Exposure Control Plan
- Hazardous Communication
- Confidentiality
  - Confidentiality in correctional healthcare
  - HIPAA Requirements
  - PREA Requirements
- Continuous Quality Improvement Orientation

Healthcare Requirements – Individual Staff

- CPR certification
- Tuberculosis Skin Testing
- Hepatitis vaccine administration/declination

Overview of Correctional Mental Health Services

- Signs of Mental Illness
- Mental Health Services
- Psychotropic Medication
- Crisis Intervention
- Suicide Prevention
- Use of Restraints

Overview of Correctional Healthcare Practices

- Access to Healthcare Services
  - Offenders' rights to healthcare
  - Co-payments
  - Offender orientation to healthcare services
  - Offender grievances
  - Informed consent and right to refuse

- Healthcare Requests
  - Sick call requests
  - Emergency services

- Continuity of Care
  - Continuity of care during incarceration
  - Discharge planning

- Special Considerations in the Offender Population
  - Special Needs Offenders
  - Pregnant Offenders
  - Impairment Aids
  - Communication on Needs
  - Medical Diets
  - Hunger Strikes
  - Terminally Ill Offenders

- Segregated Offenders
- Chronic Disease and Healthy Lifestyle Promotion
- Specialty Services
- Procedure in the Event of an Offender Death
- Documentation
- Tool and Sharps Control

Structure of Specific Contract

- Client details - web site; mission/values/vision; history; services; offender programs for education and treatment; population overview; facility descriptions
- MHM responsibilities
- MHM staffing and organization
- Professional communications/problem resolution
- Policies and procedures
- Emergency response plans
- Accreditation requirements
- Relevant Consent Decrees and/or Memoranda of Understanding
- Communication with client's administrative and facility staff

Orientation of new MHM staff includes not only the general orientation but also an onsite orientation. Onsite orientation may be provided on an individual or small group basis with information reinforced during the ongoing mentoring of the new staff member by an assigned colleague. Areas that are covered in the onsite new employee orientation typically include:

- Facility Administration – explanation of the administrative structure and introduction to designated administrative staff; tour of the facility; review of security considerations

- Security review - security as the prime directive; staffing; identification card; signing in and out of the facility; key control; contraband policy; parking; security procedures for communication and emergencies; procedures involved in the

transportation of offenders; security and mental health in special mental health placement situations; emergency and disaster plans

- Introduction to mental health staff

- Mental Health Services - mental health work area; mental health seclusion area; Kronos sign-in and out; location of restrooms and dining areas; clinic work schedules, including holiday schedules; mental health forms/supplies; telephone access process and contact numbers; team meetings; mental health training; access to copier/fax; emergency call process; treatment plan process; routine and emergency transfers; discharge planning

- Introduction to Health Services Administrator, Director of Nursing, and other medical staff, as available

- Medical Services - work areas; shift duty hours; infirmary or other special observation areas; sick call; medication procedures: order processing, pill pass times, medication non-compliance reporting, emergency medications available for psychiatry, stock medications on hand, pharmacy orders/delivery, medication renewals; referrals; process for transferring offenders to an outside hospital; emergency equipment; laboratory procedures; diet orders and snacks; limited activity notices; medical record procedures for charts; signature legend sign-in; records from outside facilities; professional problem resolution

Individual staff completion of the New Employee Orientation program will be monitored by completion of a form approved by the DDOC. This form will be maintained on a database that is routinely updated and provided to the BCHS and relevant facility administration. MHM understands that new staff will not be issued a DDOC clearance and identification card until orientation is completed. We will monitor the effectiveness of the general and on-site orientations using staff surveys and facility administration surveys. Survey data will be periodically reviewed by the MHM CQI program.

In addition to the New Employee Orientation offered to all new MHM staff, psychiatrists and nurse practitioners are provided an extensive manual for orientation to correctional psychiatric services. This manual includes information on the following topics:

- Introduction to Corrections
- Legal Mandates for Correctional Mental Health
- Who is Your Patient/Client?
- Clinical Boundaries and Safe Practices
- Tips to be a Welcomed Guest
- Who is MHM?
- Principles for Psychiatric Services
- Medication Management
- Laboratory Testing

- Treatment Compliance
- How to Work with Offenders Who Do Not Like Your Decisions
- MHM Model Policies & Procedures
- Articles Related to Correctional Psychiatry
- Contract-Specific Policies and Procedures

The Psychiatric Orientation Manual addresses the challenges typically confronted by staff new to corrections, and provides new staff a ready reference for MHM and client-specific policies related to psychiatric practices. The manual will be provided to the DDOC upon request or contract award.

Training

MHM is committed to providing ongoing training for mental health staff. MHM has developed a library of staff training modules that far exceed those expected in a correctional setting. In many of our current contracts, the training modules have received approval for compliance with staff requirements for Continuing Education Units (CEUs). Each of the training modules includes a trainer outline, trainee handout, PowerPoint presentation, trainee post-test and training evaluation, and trainee post-test answer key. As is the case with the New Employee Orientation Program, all staff training modules can be delivered with or without PowerPoint equipment.

A list of the MHM training programs currently available for mental health staff follows:

- Suicide Prevention
- Introduction to Mental Disorders
- Types of Mental Illness
- Mental Illness in Corrections
- Management and Treatment of Offenders with Serious Mental Illness
- Mental Retardation
- Working with Incarcerated Women
- Confidentiality in Corrections
- Therapeutic Communication
- Restraint Credentialing
- Behavioral Management and De-Escalation Skills with Aggressive and Self- Injurious Offenders
- Ethics and Behavior Management Principles
- Functional Assessment in Behavior Management
- Principles of Risk Assessment
- Violence Risk Assessment Part 1
- Violence Risk Assessment Part 2 - Prison Violence
- Violence Risk Assessment: Role of Correctional Officers
- Clinical Boundaries and Safe Practices
- BloodBorne Pathogens Exposure Control Plan
- HIPAA Privacy Training – Comprehensive
- HIPAA Privacy Overview

- Introduction to the Prison Rape Elimination Act
- PREA Sensitivity Training
- MHM Credentialing Process
- Introduction to Continuous Quality Improvement
- Health Record Documentation
- DSM Multi-Axial Diagnoses: Introduction
- Diagnostic Training Series: 25 Training Modules that cover the following areas:
  - Basic Foundations
  - Diagnostic Hypothesizing
  - Conducting a Mental Status Exam
  - Differentiating Among Axis I and Axis II Disorders
  - Diagnostic Pitfalls
  - Potential Pitfalls in Offender Self-Reports
- Treatment Planning: Introduction
- Creating a Multidisciplinary Treatment Plan
- Treatment Goals and Interventions
- Documenting Progress under a Treatment Plan
- Reviewing and Updating Treatment Plans
- Creating a Crisis Intervention Treatment Plan
- Documenting on the Problem List
- Developing Recovery-Oriented Treatment Plans
- Psychotropic Medication
- AIMS Testing
- Conducting Groups in Corrections
- Addressing Sleep Disturbance in a Correctional Setting
- Trauma Treatment: Part I - Post Traumatic Stress Disorder and Complex Post Traumatic Stress Disorder
- Trauma Treatment Part II: Trauma-Informed
- Trauma Treatment Part III: Gender-Responsive Treatment
- Sex Offender Programming
- Malingering and the M-FAST
- Therapeutic Response to Malingering
- Structuring and Formatting Continuous Quality Improvement Reports
- Principles of Leadership
- Principles of Management
- Urgent Care Collaboration

Review of the MHM staff training curriculum will confirm that our training programs are extensive. The Mental Health Administrator will be responsible to ensure that staff receive adequate training opportunities. These opportunities must include annual updates in suicide prevention, HIPAA and PREA requirements, site-specific emergency response plans, DDOC policies and site procedures, and DDOC risk management policies.

Beyond the New Employee Orientation program, the Psychiatric Orientation Manual, and the extensive staff training program that are made available to MHM staff, we have also begun developing Clinical Guidelines to educate and support staff in completing mental

health processes that are unique to the correctional environment. Our Clinical Guidelines currently cover the following areas:

- Behavior Management Interventions
- Mental Health Assessment of the Ability to Make Informed Medical Decisions
- Mental Health Consultation to the Disciplinary Process
- Mental Health Review of Offenders for Initial Segregation Placement
- Critical Incident Debriefing with Offenders
- Critical Incident Education with Staff
- Psychological Reconstructions (Autopsies)
- Suicide Risk Assessment

These Guidelines will be reviewed with DDOC BCHS upon contract award and revised as needed to accommodate DDOC policies and goals.

In addition to the onsite training opportunities, MHM clinical staff are offered funds on an annual basis to facilitate participation in the offsite continuing education needed to maintain licensure. Staff receive compensation for these trainings upon submission of a certificate of training completion.

In accordance with NCCHC standards, MHM maintains records of staff participation in ongoing training. These records include attendance rosters and an employee-specific database of training participation. This information will be available to the DDOC BCHS and the administration of the assigned facility. Reports about staff training will be routinely submitted in the format and time intervals requested by the DDOC.

14. Medical Administrative Committee (MAC) Meetings

Medical Administrative Committee (MAC) meetings will be held at least monthly with all Vendors, Wardens (or designated representative) of each institution and the BCHS, as required by the NCCHC Standards. The meetings are intended to provide organized and consistent communication between site administrative staff and medical personnel on issues and/or concerns. A separate meeting will be held for each level 5 facility and level 4 facilities. For this purpose, the James T. Vaughn Correctional Center, and Central Violation of Probation Center are considered to be in Kent County.

The Vendor is responsible for coordinating the schedule with the site and the BCHS. The BCHS will maintain the minutes, and conduct these monthly meetings and notify attendees of any changes in the schedule and/or location.

MHM acknowledges, accepts, and will comply with the above requirements as they pertain to the mental health/substance abuse vendor.

We routinely participate in such meetings in our existing contracts and offer the participation of our corporate support personnel to participate in these meetings routinely.

For example, it is common for our pharmacy management staff to attend such meetings to give reports on pharmacy utilization.

15. Infectious Waste Disposal

The Vendor will provide all appropriate disposal systems for hazardous waste, including needles, syringes, and other materials used in offender treatment. The Vendor will take appropriate measures to ensure that only infectious waste is deposited in the designated contaminated waste containers. Air filters used in air re-circulating and air conditioning units, which are removed/replaced by the DDOC's maintenance staff and considered to contain harmful pathogens, will be disposed of with other infectious waste by the Vendor. The Vendor shall coordinate with the DDOC's maintenance staff on the proper disposal of the filters.
The Vendor is responsible for obtaining and maintaining a BCHS approved transporter to haul infectious waste.

Infectious waste disposal is the responsibility of the medical vendor. MHM staff will cooperate fully with protocols established by the medical vendor and DDOC for the disposal of infectious waste.

16. Inspections

As required by the DDOC, NCCHC Standards, and the Delaware Division of Public Health, the Vendor is to conduct safety and sanitary inspections. The Vendor's managers are to conduct formal inspections of all areas at least monthly, with follow-up inspections to assure corrective action has been taken. Written reports are required, with copies sent to the site's Warden's Office. A record of these findings is to be included as an agenda item at the monthly Medical Administrative Committee (MAC) Meeting.

Safety and sanitary inspections are the responsibility of the medical vendor.

17. Transportation

The Vendor will arrange and pay for the use of any emergency medical vehicle, such as ambulances and medically equipped helicopters, as necessary and appropriate for emergency transportation. The expenses for these services will be included and calculated within the limitations for Catastrophic Care. No offender will be transported or removed from the State of Delaware without prior permission of the Commissioner of Correction.

Emergency transportation is the responsibility of the medical vendor.

18. Disaster Plan

The Vendor will provide a site specific disaster plan, to the BCHS and each site's Warden and/or designee, within 30 days from starting work. The plan will be coordinated with the institutions' and facilities' security plan and incorporated into the overall emergency plan and made known to all personnel. The plan must incorporate the ability to perform necessary emergency medical procedures, up to and including intubations and/or emergency airway management. The plan must account for extraordinary demands upon staff such as the possible recall of staff, safety, and security of offender and staff areas, use of emergency equipment and supplies, establishment of triage areas and procedures, evacuation procedures, and stocking of emergency supplies and equipment. Review of the health aspects of the disaster plan must be part of the initial orientation of new personnel at that site. The mock trial of the plan will be conducted annually by the Vendor in coordination with the DDOC according to NCCHC standards and in coordination with the institution/facilities mock trial.

MHM acknowledges, accepts, and will comply with the above requirements as they pertain to the mental health/substance abuse vendor. We understand that a site-specific disaster plan for mental health staff must be submitted to the BCHS and the administration of each DDOC facility within 30 days of contract start-up. Upon contract award, MHM will begin developing site-specific disaster plans for mental health staff that compliment the disaster plans of the facility and the medical vendor. It will be important to finalize these plans prior to contract start-up to ensure accurate presentation during MHM's New Employee Orientation.

MHM has developed a Model Policy and Procedure for emergency response that is consistent with NCCHC standards. Sections of this policy that we will integrate into the DDOC site-specific plans with the approval of the DDOC include the following:

- All institutions have an emergency response plan and all MHM staff are required to participate in the emergency response plan.
- A request for assistance in an emergency takes precedence over clinical activities.
- Staff are required to provide emergency contact information to the Mental Health Administrator for distribution to the Facility Administrator.
- The Mental Health Administrator submits a current employee emergency telephone roster to each facility administration and ensures that the roster is revised, as needed.
- In the event of an emergency, the designated mental health clinician will contact the Health Services Administrator to be briefed on the state of the emergency.
- Designated mental health staff will report immediately to the scene of the emergency after security staff have declared that the site is safe.
- MHM staff on duty at the time an emergency plan is activated will remain on duty until released officially by the Mental Health Administrator after consultation with the institution's administrative staff.

- In the event the emergency occurs after hours, institutional staff on duty will report the nature of the emergency to the Mental Health Administrator who will be responsible for ensuring that adequate mental health staff are available to manage the situation and victims.
- In an emergency, every mental health staff member is responsible to report to duty, if called, unless the staff member can justify the absence and is excused by the Mental Health Administrator. Staff who fail to report to work after being contacted will be subject to severe disciplinary action, which may include immediate termination.
- If communication services are interrupted, all communication must take place in accordance with the facility's emergency plan. Staff may not bring in and use personal cell phones unless given approval by facility administration.
- Unless security staff direct staff to an alternate entry, mental health staff will enter the facility through the normal entrance.
- Staff are required to identify themselves as usual during emergencies. If a staff member arrives without the identification badge issued by the client, the staff member may use a driver's license as alternate identification.
  - Mental health clinical staff roles during emergencies may include: Providing correctional staff and offenders support during and after the disaster
  - Debriefing staff and offenders after the disaster
  - Referring staff to outside support services as warranted
  - Scheduling and providing follow-up care for offenders as clinically assessed
  - Serving as an emergency response team member, when designated
  - Documenting reports and data per policy and procedures
  - Reviewing mental health records, as requested
  - Performing other duties as assigned
- Roles of mental health support staff during emergencies may include:
  - Contacting staff members not on site to assist
  - Serving as couriers for supplies, forms, and equipment
  - Taking notes for professionals, as dictated
  - Providing basic comfort and care until a clinician is available to assess or treat victims
  - Coordinating meal times for staff working extended tours of duty
  - Performing other duties as assigned

The Mental Health Administrator is responsible for ensuring that all mental health staff attend initial and annual emergency plan training to ensure that all staff understand their specific roles and responsibilities during an emergency. An issue we will stress in the orientation and annual updates is the requirement that MHM staff "perform other duties as assigned." These other duties will not include direct offender security functions but may include distributing meals and other non-clinical duties. In an emergency, MHM

staff are expected to fully contribute to the efforts of the facility to maintain safety and operations.

MHM staff will cooperate in the emergency response drills and follow-up debriefings conducted by each facility. The Mental Health Administrator and/or Medical Director staff will also cooperate in emergency response planning conducted by the facility.

19. TELEMEDICINE/TELEPSYCHIATRY EXPANSION

The DDOC sees advantage in the implementation of a telemedicine system for certain applications to provide faster access to care at remote sites and to reduce the number of off-site visits that generate substantial security costs and pose some risk to the community. Any Vendor who wishes to include a base station and remote stations as part of their plan for offender care should provide a complete written plan including the physical plant specifications required, and the equipment the Vendor will purchase to implement the system. In advance of implementation the DDOC BCHS, in conjunction with the Department of Technology and Information, must approve any proposed telemedicine program. It is intended that telemedicine be used appropriately so that it does not negatively affect the quality of care provided to the offender. The Vendor must be specific on the plans, protocols, and specialty services intended to be included in the plan. The same shall be done for telepsychiatry. The Vendor shall report monthly to BCHS on the status on the telemedicine and telepsychiatry programs.

MHM has included telepsychiatry as part of our proposal, see *Tab5, Section IV, u.*

20. DACS DATA ENTRY MANDATORY

The Delaware Automated Correctional System (DACS) is a web-based offender management system. DACS uses Oracle Database© and Oracle© tools to store and retrieve data. Use of the DACS medical module and all the components therein is a material requirement of any health care services contract. This includes mandated data entry related to intake, transfer, scheduling, chronic care, specialty consult, Sick Call and mental health appointments, and any subsequent additions to the medical module. Initial training on the system will be provided by DDOC staff. Follow up training will be provided by the Vendor.

MHM will ensure that mental health and substance abuse staff utilize the Delaware Automated Clinical System (DACS) as required by the DDOC. See *Tab 5, Section IV, c.*

21. STATE/DDOC OWNERSHIP OF ALL DOCUMENTATION

All documents, charts, data, studies, surveys, drawings, maps, models, photographs and reports or other material, in paper, electronic or other format, are the property of the State of Delaware and remain as such at the end of the contract, no matter the

reason for the contract termination. Further, DDOC shall have immediate access to all records on demand.

MHM acknowledges, accepts, and will comply with the above requirements.

22. Maintenance of Records

The Vendor is responsible for maintaining the offender records to be in compliance with all federal and state laws, policies and regulations including but not limited to 11 *Del. C.* §4322.

MHM acknowledges, accepts, and will comply with the above requirements as they pertain to the mental health/substance abuse vendor (the responsibility for maintenance of the medical record lies primarily with the medical vendor). See *Section 4.iv,* above.

23. Offender Insurance

The Vendor will seek and obtain payments and reimbursement from third party insurers for those offenders who are covered by health insurance including Medicaid.

The Vendor shall gather the information needed to process claims and retain such information for auditing and inspection by DDOC. The Vendor will credit the DDOC 100% of Medicaid costs. These credits will be included with the Vendor's basic medical monthly services invoice/credits and will be clearly noted. The Vendor is invited to propose alternative methods, subject to the approval of the Department, for retrieving and accounting for insurance re-imbursements provided to cover offender healthcare services.

MHM will comply with this requirement to the extent it applies to mental health services. We currently provide mental health services to nine state correctional systems and know of no reimbursement from third-party payers for mental health services for offenders. In reviewing the answers to vendors' questions in regards to this matter, it appears this is an issue for the medical vendor.

24. Transition Plan between Existing and New Vendor

The Vendor must develop a transition plan from the current service delivery system. The transition plan will address an orderly and efficient start-up. A detailed plan must be submitted with the each proposal that addresses, at a minimum, how the following issues will be handled during the transition:

1. **Recruitment of current and new staff**
2. **Subcontractors and specialists**
3. **Hospital services, including off-site secure unit**
4. **Pharmaceutical, laboratory, radiology, dental and medical supplies**

5. **Identification and assuming current medical care cases**
6. **Equipment and inventory**
7. **Medical record management**
8. **Orientation of new staff**
9. **Coordination of transition**

The Vendor must outline timetables and personnel that will be assigned to supervise and monitor the transition, and detailed plans, including offender medical file transfer, for the transition from the DDOC's system to your system on an institution-by-institution basis which will include timetables for completion.
If the Vendor is going to integrate the current Vendor's employees and/or subcontractors, the Vendor must specify how it intends to integrate them.
The Vendor's plan must outline how it intends to transfer offender medical files.
Contracts may be involuntarily extended, not more than 180 days, to provide these services.

The Vendor's plan must also summarize problems anticipated during the course of transferring the contract to a new vendor at the end of the Vendor's term, including any proposed solutions. The Vendor must provide resumes for the management staff expected to be hired by the Vendor at both Regional and Institutional levels. The Vendor must provide credentials for all medical providers as determined by BCHS. The Vendor will provide a similar transition plan at the end of a contractual period for transition to a new contract or a new Vendor.

MHM acknowledges, accepts, and will comply with the above requirements.

MHM fully understands the broad scope of tasks involved with transitioning statewide, multi-facility correctional behavioral health programs. We have successfully completed state correctional system transitions in more than ten states, often under extreme time constraints (e.g., less than 30 days) and even simultaneously. In 2008, we simultaneously transitioned statewide mental health programs for the Departments of Corrections in Missouri and Massachusetts in 30 days, including the successful hire and transition of over 500 new employees.

The timeframes for the implementation of our two previous contracts with the Florida Department of Corrections were each less than three weeks from the date of notification. When we were awarded the Florida mental health program in 2005, we were able to transition staff and assume management responsibility within a two-to-three week period, during which we filled approximately 200 positions between mid-December and January 1st, the contract start date. In November 2006, MHM was awarded another contract by the Florida Department of Corrections to assume staffing responsibilities for nearly 400 medical positions. We filled the positions in less than three weeks.

The following table demonstrates our track record of success in implementing new contracts in a timely manner:

Contract	Year Contract Started	MHM Implementation Time
Alabama Department of Corrections	2003	5 days
Florida Department of Corrections: Region IV *(Mental Health Services)*	2006	15 days
Maryland Department of Public Safety & Correctional Services	2005	28 days
Massachusetts Department of Correction	2007	30 days
Missouri Department of Corrections	2007	30 days
New Hampshire Department of Corrections	2008	30 days
Pennsylvania Department of Corrections	2003	35 days
Vermont Department of Corrections	2005	14 days

Recruitment of current and new staff

MHM is bidding on the mental health and substance abuse components of the RFP. We understand that the start-up of these programs will require a smooth transition of services from the two vendors currently responsible for these programs, as is the case with all of our contract start-ups to date. Typically, when there is a change of vendors there is a high level of anxiety among the current program staff, facility administrators, and central office managers stemming from the uncertainties about the future of the program; and for the current program staff, the future of their employment. These are natural concerns, and we take immediate action to dispel this anxiety and the rumors that tend to surface during the transition period.

Upon notification of award, we like to immediately meet with Department officials and other stakeholders (in this case the other selected vendors) to review our start-up plan. We will also immediately prepare a written "welcome letter" for distribution throughout the facilities introducing MHM and presenting information about the transition, including phone numbers so that field staff have an immediate resource for answers to questions. We also dispatch a large start-up team comprised of MHM program managers from our other programs as well as other corporate and regional staff to go on site to all prison facilities to hold introductory meetings with program staff and facility administrators. Our goal is to have an immediate onsite presence at all facilities to relieve anxieties within the first few days of the start-up period. It is not uncommon for us as the mental health contractor to have more start-up personnel on the ground in the prison facilities than our medical vendor counterparts.

We also are cognizant of the need to ensure there are no lapses in care during the transition period, and therefore, we include seasoned correctional healthcare administrators on our transition teams. We already have identified the key facilities which have large mental health programs and service needs and are poised to immediately provide management personnel to these facilities during the transition phase.

Delaware's proximity to our corporate headquarters in Vienna, Virginia, as well as our Maryland regional office in Baltimore, will bring added resources to the start-up. Additionally, we have staff nearby in our Philadelphia and Pennsylvania contracts to aid in the transition if needed.

See *Tab 4, Section X, C.2* for our extensive recruiting plan.

Current Staff

In most of our correctional mental health programs, we are able to be fully staffed and operational within 30 days of award. This short timeframe for start-up is often made possible due to there being an in-place complement of staff to 'rollover' to MHM. However, there is often a misperception among staff at the facility level that the new incoming vendor will be terminating all existing personnel and bringing in a completely new team of staff at all levels of the program. Although we have already initiated recruiting activities in Delaware to help ensure staffing of all positions upon the contract start date, we consider the existing staff as our primary pool of candidates for recruiting. We give first consideration for employment with MHM to those staff currently working in the facilities who wish to remain in their positions and, most importantly, are in good standing with the Department.

It is our understanding that many of the current psychiatric staff are engaged as independent contractors. Upon contract award, we will seek to engage these personnel as employees of MHM. In most cases, we successfully transition the vast majority of existing personnel, such as our Missouri program where we were able to transition the majority of independent contractors to our employee model (see *Tab 2, Section III, B.1)*. As mentioned previously, we have found our employment model more advantageous in that it meets the requirements of the Internal Revenue Service for employer-employee relationships (i.e., payroll taxes) and, more important to our clients, it results in lower turnover and a higher level of commitment from employees to the success of the program.

New staff

MHM has already started the process of studying the Delaware market and sourcing for candidates for the positions in our staffing plans. As stated above, we will give first priority to existing personnel, but we know that our staffing pattern may vary from the existing staffing pattern resulting in new positions or there may be existing vacancies or some turnover during the transition that will require us to recruit and place new employees. Also, we know that to maintain our overall company staffing rate of over

97% we will need to build and maintain a ready supply of qualified candidates to be able to rapidly fill any vacancies that occur over the term of the contract.

Subcontractors and specialists

MHM does not intend to use subcontractors or outside specialists in Delaware. As discussed previously, it is our understanding that the current vendor is using independent contractors for psychiatry positions. Upon contract award, we will try to engage those clinicians in good standing with the DDOC as *employees* of MHM.

Identification and assuming current medical care cases

As stated above, we will dispatch our start-up team to be on site at all correctional facilities as soon as allowed after notification of award of contract. For mental health cases, we will meet with the mental health program personnel at each facility, review the current caseload, and identify high-risk mental health patients and any special treatment needs or risks during the transition period. Typically for the mental health program, this involves ensuring adequate staffing coverage, particularly in psychiatry. Due to Delaware's dual mission as a jail and prison, this also includes ensuring full staffing at intake areas to be able to respond to the mental health needs of incoming offenders.

Equipment and Inventory

Compared to the general medical program, the equipment and inventory needs of the mental health and substance abuse programs are minimal. However, we will be equipping our new Delaware regional office with standard office equipment such as computers, phone system, copier, etc. There are some clinical supply and equipment needs at the facility level, particularly for the substance abuse program (i.e., interactive journals, clinical modules, subscriptions, training and education aids, audio-visual equipment, etc.). We will order these materials upon notification of award.

During the initial site visits to the facilities we will assess the availability and condition of computer equipment and other program supply needs for clinical and administrative personnel as well as internet connectivity for electronic mail. We have an in-house corporate IT Department that will work on any computer equipment purchase and installation issues, including telemedicine (i.e., telepsychiatry) equipment installation.

Medical Record Management

As the mental health and substance abuse vendor, we will adapt to and utilize the global medical records system. We are accustomed to using a variety of medical records systems including electronic medical records, consolidated medical/mental health records, and records systems that use a separate mental health record. We will provide training for our staff on the proper use of the medical records system and establish documentation standards specific to the Delaware program.

Orientation of New Staff

A description of our employee orientation program can be found in *Tab 4, Section X, C.3.*

Coordination of Transition: Start-Up Team

For each new contract, we establish a start-up and transition team and assign a MHM Vice President to oversee the start-up. For Delaware, Rock Welch, our Senior Vice President of Operations, will direct the start-up activities. As mentioned before, Dr. Robert "Mike" Hooper will be the Regional Director over the Delaware program. His history and familiarity with the Delaware DOC will be integral to our start-up efforts. The department heads from MHM's Human Resources, Recruiting, Clinical Operations, Pharmacy Management, Administration, and IT Departments will each coordinate the activities relative to their department's areas.

Our start-up team will be comprised of the following individuals:

Name and Title	Role in Start-Up
Rock Welch, MS Senior Vice President, Operations	Mr. Welch will provide overall supervision and direction to the Delaware start-up and transition. He will coordinate the development and execution of all start-up action plans.
Dr. Mike Hooper Regional Director	Dr. Hooper will supervise, at a local level, the implementation of the mental health and substance abuse programs. He will be the chief point of contact for the DDOC.
Jane Haddad, PsyD Vice President, Clinical Operations	Dr. Haddad oversees MHM's Clinical Operations Department and will coordinate her department's initial clinical operations review of the Delaware mental health and substance abuse programs. This will involve an initial site visit to review clinical operations, identify any immediate and urgent deficiencies, and implement an action plan to remedy any major deficiencies. Dr. Haddad will assign representatives from her department to conduct the initial site visit to and will coordinate this with the Department's staff. Results of findings will be made available to the Department.
Ethan Gill Vice President, Human Resources	Mr. Gill will supervise and direct activities related to recruitment, hiring, enrollment, and orientation of employees. These activities include the recruitment of existing State employees and new employees to fill any vacancies.

Name and Title	Role in Start-Up
Regina Meyers, Director of Recruiting	Ms. Meyers will directly oversee the recruiting process. She is supported by a team of 12 recruiting professionals.
Brenda Sloan Director of Office Management	Ms. Sloan has coordinated the administrative efforts of numerous MHM start-ups and will be responsible for training administrative personnel.

MHM's start-up activities are supported by the resources of MHM's Corporate Office in Vienna, Virginia, with daily review from the President and Chief Operating Officer, Steven H. Wheeler.

Anticipated Problems

MHM does not foresee any major problems during the transition of the Delaware mental health and/or substance abuse programs. We do foresee the ordinary challenges of converting staff, filling vacancies, learning the nuances of each facility, orienting new managers and field personnel, and the process of beginning to make reforms to the programs to improve their effectiveness and efficiency. In order to meet these challenges, MHM has already begun speaking with Delaware licensed psychiatrists who are interested in working with us.

Resumes for Management Staff

As discussed in *Tab 2, Section III, B.1,* the management staff allocated for the Delaware program are **Rock Welch**, **MS**, Senior Vice President of Operations and **Robert "Mike" Hooper**, **PhD**, Regional Director of Delaware and Maryland. Their resumes are included in **Attachment D**. Although we have identified a highly qualified candidate for the Program Manager of the Substance Abuse Treatment Program, this individual has asked not to be named until contract award.

MHM Transition Plan

With an anticipated award date of April 23, 2010 and a contract start date of July 1, 2010, the likely timeframe between date of award and contract start date will be approximately 60 days. This is a sufficient timeframe for MHM to conduct all the start-up activities for a smooth transition. During this timeframe, we will conduct a variety of start-up related activities as outlined in the table below. In fact, some of the activities are already underway in anticipation of award. We will also continue activities related to the start-up of the program into the first weeks and months of the program.

Task List	Responsible Party	Estimated Time Line
Pre-Notification Tasks		
Market Analysis & HPSA designations identified	Recruiting	Underway
Salary Surveys	Recruiting	Completed
Sourcing for Licensed Professionals	Recruiting	Underway
Staffing Matrix	Recruiting	Completed
Sourcing for Regional Psychiatric Director	Recruiting	Underway
Sourcing for Program Manager and Admin. Assts.	Recruiting	Underway
Assign Start-up team members and leader (Rock Welch, Sr. Vice Pres.)	Chief Operating Officer	Completed
Identify Delaware office space	Admin. Services	Underway
Compliance with Delaware business requirements	Finance	Underway
Notification of Award of Contract	**April 23, 2010**	
Schedule kickoff meetings with DDOC (identify points of contact; set communication systems and meeting schedules)	Chief Operating Officer	ASAP
Obtain list of current employees; obtain dates, times, and locations for meeting staff; commence interviews with existing staff	Start-up team	ASAP
Distribute introductory letter to stakeholders and facilities describing MHM and services to be provided (designed to alleviate concerns and rumors that typically surround a new contract)_	Start-up team	Upon contract signing
Present candidates for key management positions (program managers, regional psychiatric director, etc.) to DDOC for review and approval and issue offer letters of employment.	Human Resources	Upon contract signing
Activate telepsychiatry start-up team activities	Telepsych. Team	Upon contract signing
Set-up credentialing filing and management system for psychiatrists	Human Resources	April 2010
Schedule and conduct initial site visits at key facilities	Start-up team	1st week in May
Open Delaware office (install phone system, IT services, and furnishings)	Admin. Services	June 1, 2010

Task List	Responsible Party	Estimated Time Line
Establish payroll procedures for new staff and time keeping system	Payroll	June 1, 2010
Execute Lease Agreement for Delaware office	Admin. Services	June 1, 2010
Obtain necessary security clearances and IDs for key staff	Program Manager	June 11
Activate IT and communication systems for new staff (email, cell phones, internet access, etc.)	IT	Mid December
Program Manager, Chief Psychiatrist, CQI Coordinator, and Admin. Asst. orientation	Various	December 15
Contract Start Date	**July 1, 2010**	
Activate any new staff recruited prior to contract start date	Various	July 1
Clinical Operations Review	Clinical Operations	July 5 - 9
Develop Contract Compliance Indicators	Clinical Operations	Within 90 days of start date
Conduct Initial Contract Compliance Audit	Clinical Operations	December 2010
Start-up review and operations meetings with DDOC	MHM / DDOC	Weekly for first 30 days, then monthly thereafter.

TAB 4. ADMINISTRATION

MHM acknowledges that the administrative services detailed in *Section II, C, X* of the RFP are to be provided by the Medical Services Vendor unless otherwise specified. However, since many of these requirements affect *each* of the vendors, we have detailed our administrative approach as it pertains to the mental health/substance abuse vendor.

A. COORDINATION AND COMMUNICATION WITH DDOC

To ensure that DDOC's needs and the medical needs of the offenders are met, each Vendor must coordinate closely and communicate regularly with the warden or designee in each facility and, with the BCHS. Coordination and communication are a priority issue for the DDOC. Many incidents, security issues, miscommunications, and insufficient or inappropriate medical care can be avoided through appropriate communication and coordination.

Although some communication requirements are specified in the RFP, the DDOC expects the Medical Services Vendor to establish daily communication protocol with the DDOC BCHS and facility administrative staff that is approved by the Bureau Chief. The DDOC also expects that Medical Services and Mental Health Services Vendors' administrative staff have a single contact person in each facility and that the contact person be available in the facility on a daily basis. The Vendor is responsible for informing DDOC of a change or substitution, whether temporary or permanent, of the single contact person in each facility. The Vendor must keep the DDOC administrative staff in each facility informed of issues and problems, their resolution, special needs and special medical circumstances as well as any other pertinent medical information.

In addition, the DDOC expects the Medical Services Vendor to coordinate closely with the administrative and security staff in each facility in regard to Sick Call, off-site appointments, medication distribution and other medical services. It is the Vendor's responsibility to coordinate with the DDOC BCHS and facility administrative staff in the provision of medical services.

MHM acknowledges, accepts, and will comply with the above requirements as they pertain to the mental health/substance abuse vendor.

We will take proactive steps to ensure a high level of communication between MHM and other stakeholders, particularly the administration of each correctional facility. We will establish a local regional office in Delaware with locally-based program managers for the mental health and substance abuse programs, a designated chief psychiatrist, administrative assistants, and other support services rather than attempt to manage the program remotely from an out-of-state office. Additionally, Dr. Robert "Mike" Hooper, our current Maryland Program Manager, will be promoted to Regional Director over our Maryland and Delaware programs. Due to his long history in working with the Delaware Department of Corrections, we will establish Dr. Hooper as a primary point of contact for

the Delaware mental health and substance abuse programs. Dr. Hooper is well known throughout the Delaware prisons, and has strong relationships with many of the Delaware DOC personnel. Dr. Hooper will maintain a high level of visibility throughout the Delaware prisons and with DDOC central office staff.

We will also establish two Program Managers, one for the substance abuse program and the other to directly oversee the mental health program. These individuals will report directly to Dr. Hooper. The two Program Managers and Dr. Hooper will be required to establish and maintain working relationships with stakeholders from the DDOC and other personnel involved in the mental health, substance abuse, and medical programs; and will be accessible at all times via office or cell phone including after hours, weekends, and holidays. These managers will each carry a mobile phone with email capabilities (i.e., Blackberry) to further facilitate a high level of communication and access. Similarly, the designated lead psychiatrist will function in a medical director capacity over the mental health and substance abuse programs and will also be readily available and establish lines of communication with all stakeholders.

Rather than depending solely on rigid, formalized meetings that occur on a fixed frequency or written memoranda, we feel it is important to establish an active, ongoing dialogue between stakeholders on a day-to-day basis. This dialogue is then supported by regularly occurring stakeholder meetings, such as monthly operational meetings. We want all stakeholders to feel comfortable reaching out to MHM, without hesitation, and to expect a high level of responsiveness from our staff, local management team, and corporate support personnel.

We will also establish leadership at each facility by designating an MHM staff member as the primary point of contact for facility administrative personnel, as well as personnel from other vendors. Depending on our staffing plan for each facility, this individual may be one of the facility based mental health directors, a senior social worker or counselor, or senior mental health worker.

One further example of our dedication to collaboration with the State is that we share the results of our internal audits with the client (see *Tab 3, Section II.B.4.vii*).

For further information regarding communication, see *Section C.16*, below.

B. DACS DATA ENTRY MANDATORY

The Delaware Automated Correctional System (DACS) is a web- based offender management system. DACS uses Oracle Database© and Oracle© tools to store and retrieve data. Use of the DACS medical module and all the components therein is a material requirement of any health care services contract. This includes mandated data entry related to intake, transfer, scheduling, chronic care, specialty consult, Sick Call and mental health appointments, and any subsequent additions to the medical module. Initial training on the system will be provided by DDOC staff. Follow up training to be provided by the Vendor.

MHM addresses DACS data entry as it pertains to the mental health/substance abuse vendor. See *Tab 5, Section IV, c* and *Tab 6, Section XI, E.*

C.1. Obligation for Facility Health Unit Administration

Each Vendor shall identify a management staff member for each major facility who shall be responsible to the Vendor for corporate and administrative functions related to contract implementation and for liaison activities with the Bureau Chief. Unless noted above, this individual may be at the facility or regional level and his/her job description is subject to advance written approval by Bureau Chief. The Vendors are responsible for daily communication with the BCHS Regional Administrators according to the established protocols for communication developed by the Vendor and approved by the Bureau Chief.

Please refer to *Tab 2, Section III, B.1* and *Tabs 5* and *6.*

C.2. Recruitment and Retention

Each Vendor responsible for providing staff to the DDOC under this solicitation must have a continuously active recruitment and retention operation designed to attract qualified health professionals and keep all positions filled, especially clinical positions. The plan must be in writing and accepted by the Bureau Chief.

MHM acknowledges, accepts, and will comply with the above requirements.

Maintaining low turnover rates of healthcare personnel in correctional settings (in an already competitive healthcare staffing market) is a major challenge. To meet this challenge, MHM invests heavily in the front-end recruitment resources necessary to identify and attract qualified professionals. We have an excellent record of being able to recruit and retain clinical and administrative personnel to work in challenging correctional environments. In fact, our overall fill rate for the company's over 2,000 positions is 97 percent.

Our Recruiting Department is comprised of a team of 12 professional healthcare recruiters and is *by far the largest in the correctional healthcare industry*. Our recruiters are strategically placed throughout the country so they can support the recruitment needs of each MHM contract at a local level. Further, MHM will have a dedicated staffing specialist responsible for maintaining staffing for the DDOC contract.

We emphasize a proactive approach, establishing candidate pools so that credentialed resources are available from which to fill newly-created and interim positions, thus minimizing the use of outside temporary staff.

MHM continually assesses staffing levels, anticipates personnel changes, and conducts recruitment activities to ensure that absences or vacancies are promptly filled. Recruiters

work with professional organizations, employment agencies, and staffing firms to identify contingency candidates for unexpected or extended absences due to illness, family emergencies, or other circumstances.

Recruiters identify potential applicants for permanent and temporary positions in a variety of ways. These include:

- Purchasing physician mailing lists and sending direct mailings to qualified applicants
- Placing targeted advertisements in professional journals (print and Internet)
- Employing Internet job boards and the MHM corporate website to post positions
- Advertising in local and regional newspapers and other publications
- Posting positions with universities and residency programs
- Setting up exhibitions at association job fairs, trade shows, and conferences
- Conducting open houses and facility tours to attract candidates
- Using telemarketing (mail and telephone) locally and regionally

MHM is also applying technology to further the capabilities of our Recruiting Department. We are currently implementing a new recruiting and applicant tracking software system to enhance our ability to source, track, and maintain communication with literally thousands of healthcare professionals. Additionally, we are using technology to drive and manage an Employee Referral Program, in view of statistics confirming that this decreases time-to-hire and increases retention.

Recruiting Process:

Our core strategy for successful recruitment is based on the following progression:

1. MHM assigns a dedicated professional recruiter who is well acquainted with facility and DDOC requirements.
2. MHM staff confirms position specifications based on DDOC requirements, including credentials and qualifications.
3. Recruiters initiate a candidate search using all available resources, including MHM-customized provider databases.
4. MHM staff pre-screens candidates by surveying for specific qualifications and experience related to the position.
5. Staff members refer pre-qualified candidates to MHM's Program Manager who schedules and conducts on-site interviews.
6. MHM staff schedule facility tours to review working conditions as well as safety and security systems.
7. Recruiters introduce prospective candidates to key facility staff with whom they will collaborate.

8. MHM recruiters confirm special candidate qualifications and consult with the Program Manager on candidate selection.
9. MHM submits selected candidates to the DDOC for security and other clearances.
10. MHM staff confirms that basic licensure prerequisites are met, in good standing, and extends offers. Primary source verification of the applicant's credentials and educational background, as well as all relevant licensure and certification, are completed during the credentialing process, which begins immediately upon employment.
11. MHM follows up with each new employee prior, during, and after their first day to ensure all questions and/or concerns are addressed.
12. Recruiters maintain a continuing relationship with the provider hire to ensure successful employment under the contract.

MHM's Physician Employment Model for Improved Retention

Our best recruiting tool is the long-term retention of quality employees. We recognize that recruitment is just one component of maintaining an effective workforce. MHM considers retention and minimizing turnover to be equally important.

We strive to increase employee retention through a variety of initiatives designed to provide employees with a professionally rewarding, positive work experience. Our employment model, our continuously refined compensation and benefits packages, and our human resources systems all create a better work experience for our staff.

Unlike some vendors, who routinely independently contract for professional staff, MHM retains staff through formal employment relationships. We believe the employment model for retaining personnel is beneficial to our clients because employees are more engaged in the success and mission of the company and their worksites than are independent contractors. Not only does it enhance quality, but it also ensures compliance with Internal Revenue Service guidelines – thus providing a twofold benefit.

We support our staff by offering a competitive compensation and benefit package designed to retain valued personnel. Compensation is measured against the market through in-depth research, taking into consideration the scarcity of a specific discipline and the remoteness of a location. As employees of MHM, staff receive a benefits package that includes the following:

- Paid Life Insurance
- Medical, Dental, & Vision
- 401(k) Savings Plan
- Paid Short-Term & Long-Term Disability
- Paid CEUs
- Up to 40 Paid Days off Annually
- Paid Holidays

- Competitive Hourly Rates
- Flexible Spending Accounts
- Shift Differential
- Company-Paid Malpractice Insurance

DDOC Recruiting Plan

The recruitment and retention of Psychiatrists is key to the success of the Delaware Mental Health Bid. To be successful, a very strategic, integrated and comprehensive approach is necessary. Below, we highlight our recruiting plans. In preparation of this proposal, we have begun our recruiting efforts and have gathered demographics and pertinent statistics to aid in the process (see **Attachment D**).

Delaware Comprehensive Recruiting Plan
Psychiatrists and Psychiatric Nurse Practitioners

Psychiatrists and Psychiatric Nurse Practitioners are in low supply and high demand, particularly in rural areas and smaller cities.

MHM utilizes the skill and expertise of its experienced recruitment staff to execute a specific, targeted and comprehensive plan to attract candidates and to guide them through to successful placement in the Delaware DOC facilities. These strategies include:

1. **On-Line Advertising & Resume Searching** Sites utilized include:
   - HealtheCareers which encompasses all of the following:
     - MedHunters.com
     - American Psychiatric Association
     - American Medical Association Alliance
     - Student Doctor Network
     - American Academy of Nurse Practitioners
     - American Nurses Association
     - American Psychiatric Nurses Association
     - American Academy of Physician Assistants
   - CareerBuilders
   - PracticeLink
   - PhysicianWork.com

2. **Broadcast Email Campaign**
   - Reaches a large number of passive candidates very quickly
   - We will target Psychiatrists around the US who have active or inactive DE licenses or any ties to the state of Delaware. We will also target Psychiatrists in surrounding states including Maryland, Pennsylvania and New Jersey.

3. **Print Advertising**
   - MHM utilizes display ads and classified ads in medical journals, newspapers, association and society newsletters.

- All of the following publications will be utilized: ***Psychiatric News, Psychiatric Times, Current Psychiatry,*** Psychiatric Society Newsletters and selected newspapers around the state.

4. **Targeted Calling & Voice Blasts**
   - MHM obtains physician and mid-level provider lists from which to do targeted cold-calling as well as larger voice blast campaigns.
   - Both methods are useful in reaching passive candidates and networking to seek referrals.

5. **Direct Mail Campaigns**
   - Postcards and flyers are mailed to large lists of Psychiatrists and Psychiatric Nurse Practitioners in order to attract passive candidates.
   - MHM has a proven track record of success with our direct mail campaigns.

6. **Referrals**
   - MHM has an effective referral plan in place for current employees to recommend candidates and receive a referral bonus upon successful placement of candidate
   - MHM also seeks referrals outside the company from local physicians, mid-level providers, nurses and clinical managers.

7. **Conferences** – MHM attends key conferences to attract qualified candidates. Some examples are:
   - American Psychiatric Association Conference
   - American Psychiatric Nurses Association Conference
   - US Psychiatric & Mental Health Congress
   - State Psychiatric Society Conferences & Meetings
   - **Delaware Psychiatric Society** MHM enjoys very successful State Psychiatric Society relationships in Pennsylvania, Maryland, Missouri, Alabama and Georgia to name a few. Partnering with the Delaware Psychiatric Society will allow for unique and personal recruitment opportunities that have proven highly effective in our other states.

8. **HPSA/NHSC Recruiting**:
   MHM has expertise in obtaining mental health HPSA designations for state correctional facilities and will seek designations for all Delaware DOC facilities that qualify. Once the HPSA designations have been granted, MHM will work with the DOC to facilitate the NHSC Recruitment & Retention approval. This approval will then allow Psychiatrists, Psychiatric Nurse Practitioners and other treatment team members to apply for NHSC Loan Repayment – an extremely attractive program to mental health clinicians.

9. Academic Program Recruiting

- Key academic programs are identified by recruiters and personal contact is made with each of them.
- Resident/Fellow Newsletter sent nationwide each quarter.
- Dinner and luncheon events are held at key programs to present corrections opportunities.
- Guest speakers are provided to programs for various correctional healthcare topics.
- Continuous marketing to residents/fellows and graduating Psychiatric Nurse Practitioners via email campaigns, targeted calling, direct mail pieces and personal program outreach.
- The following are academic programs that will be targeted for recruiting Psychiatrists and Psychiatric Nurse Practitioners:

Psychiatry Residency Programs:

- **Delaware Psychiatric Center Program**
  New Castle, DE 19720
- **University of Maryland/Sheppard Pratt Program**
  Baltimore, Maryland
- **Johns Hopkins University Program**
  Baltimore, Maryland
- **Drexel University**
  Philadelphia, PA
- **Jefferson University**
  Philadelphia, PA
- **University of Pennsylvania**
  Philadelphia, PA
- **Penn State University**
  Hershey, PA

Psychiatry Fellowship Programs:

- **University of Maryland Forensic Psychiatry Program**
  Jessup, Maryland
- **University of Pittsburgh Forensic Fellowship Program**
  Pittsburgh, PA

Targeted Psychiatric Nurse Practitioner Programs:

- **University of Maryland Psychiatric NP Program**
  Baltimore, Maryland
- **University of Pennsylvania Psychiatric NP Program**
  Philadelphia, PA
- **Robert Morris University Psychiatric NP Program**

Philadelphia, PA
- **Drexel University Psychiatric NP Program**
  Philadelphia, PA
- **University of Pittsburgh Psychiatric NP Program**
  Pittsburgh, PA

Delaware Recruiting Plan
Psychologists and Mental Health Professionals

1. **On-Line Advertising:**
   Sites to utilize:
   - CareerBuilder.com
   - Psychcareers (American Psychological Association)
   - NASW (National Association of Social Workers)
   - AMHCA (American Mental Health Counselors Association)
   - Delaware Psychological Association
   - Delaware Counseling Association

2. **Print Advertising**
   MHM utilizes display ads and classified ads in newspapers, association newsletters and journals, including:
   - American Psychological Association
   - Local newspapers
   - National Association of Social Workers Delaware Chapter Newsletter

3. **Direct Mail Campaigns**

   - Postcards and flyers are mailed to Psychologists and Mental Health Clinicians; these can be to those nationwide who are licensed in Delaware or to those living in the state and neighboring states.
   - MHM has a proven track record of success with our direct mail campaigns

4. **Referrals**
   - MHM has an effective employee referral plan in place for current employees to recommend candidates and receive a referral bonus upon successful placement of candidate

10. **Conferences/Job Fairs** – MHM attends association conferences in the different disciplines as well as in correctional health care and mental health care.

11. **Academic Program Recruiting** – MHM will reach out to College/University programs in Psychology, Social Work, and Mental Health Counseling to make contact with students and attend any career events. We can do this in the State of Delaware and also surrounding states. Some Delaware programs include:
    - University of Delaware: Psychology Doctorate Program

- Delaware State University: MSW Program
- Wilmington University: MS Degree in Community Counseling
- Springfield College, School of Human Services, Wilmington, DE: MS Degree in Human Services/Mental Health Counseling Concentration

C.3. New Employee/Contractor Training and Unit Orientation

Each Vendor responsible for providing staff under this solicitation must have a written New Employee Orientation and Training Plan and a system for quickly moving new employees through the training. The Vendor must work closely with the Bureau Chief to coordinate Vendor's orientation and training programs with DDOC mandatory new contractor training/orientation modules. In addition, the Vendor must have a system for privileging licensed and certified health care professionals that targets essential basics for safe offender care. A program for clinical skills update for all health professionals is also required in the written plan. DDOC-approved suicide prevention training is mandatory for all on-site Vendor employees.

As part of the plan, the Vendor must provide basic orientation training and biennial updates to DDOC officers on the recognition of altered physical or mental states associated with medical conditions.

The Vendor will be held accountable for providing monthly updates (electronically) on DDOC staff orientation and training including specific training/orientation by facility and the individuals involved.

MHM acknowledges, accepts, and will comply with the above requirements.

Orientation

MHM's orientation program focuses on the following: (1) agency contract requirements, policies and procedures, MHM requirements, and contract compliance in a correctional setting; (2) clinical issues specific to corrections; and (3) administrative requirements. We will include the Department's contract clinical administrators and medical leadership as trainers and presenters. MHM clinical operations and administrative staff will also participate in orientation.

We will schedule a pre-service session between the Program Manager and each new provider before they assume permanent duties. In addition, we arrange an orientation promptly upon contract award so that the employee begins work on day one of the contract knowledgeable about the duties, contract requirements, and MHM policies and procedures governing service.

Orientation for MHM providers includes an in-depth orientation to agency contract requirements, policies and procedures, MHM requirements, and contract compliance in the correctional setting:

- History and background of MHM
- MHM's benefits package
- Orientation to MHM's organization and resources
- MHM and DDOC policies and procedures
- Overview of MHM's contract with the DDOC
- Contract monitoring and performance measures
- Complaint and grievance policy
- Facility safety and security

Orientation for MHM staff will also discuss diverse clinical topics to strengthen clinical skills. Included is information about treatment issues pertaining specifically to inmates and their environment with emphasis on the critical importance of safety and security and of maintaining an integrated and collaborative working relationship with security, medical, substance abuse, and other treatment staff and personnel. The manual includes the following topics:

- Introduction to Corrections
- Legal Mandates for Correctional Mental Health
- Who is Your Patient/Client?
- Clinical Boundaries and Safe Practices
- Tips to be a Welcomed Guest
- Who is MHM?
- Principles for Psychiatric Services
- Medication Management
- Laboratory Testing
- Treatment Compliance
- How to Work with Inmates Who Do Not Like Your Decisions
- MHM Model Policies & Procedures
- Articles Related to Correctional Psychiatry
- Contract-Specific Policies and Procedures

The Psychiatric Orientation Manual addresses the "challenges" typically confronted by staff new to corrections as well as provides new staff a ready reference for MHM and client-specific policies related to psychiatric practices.

Through a combination of group and individual activities within the first week of employment, we complete a checklist of topics to document that each staff member participated in the training and understands the key content. Through regular staff meetings and review of relevant metrics (e.g., timeliness of service), we monitor and evaluate how well the providers are performing to meet the expectations of the contract. MHM also provides a training session (or individual instruction, as appropriate) on organizational and human resource requirements. This session includes the position's administrative requirements within MHM under the specific contract and instruction on the following:

- MHM policies and procedures
- Time and attendance systems and requirements
- Workers' Compensation
- Absentee policy
- Payroll change notice
- Vacation and other special requests
- Communications (i.e., calling cards, pagers, correspondence)

Employee orientation will include the distribution of the MHM Employee Handbook and on-site training. Training materials will be made available to the Department for review prior to the initiation of staff orientation.

Training

Because the nature of our work requires the provision of clinical services by advanced degreed, licensed professionals (and training is a component of their requirements for maintaining licensure), it is incumbent upon us to make sure our staff receive the most up-to-date information regarding practice advancements in the field. Additionally, due to the high levels of security and other variables unique to providing mental health services in a correctional environment, there is a significant need for training that goes beyond the academic aspects of the field of mental health. These have to do with altering treatment approaches to meet the unique needs of the correctional population within high security constraints.

Therefore, MHM has developed a library of over 40 staff training modules that exceed those required by NCCHC or ACA. Each of the training modules includes a trainer outline, trainee handout, PowerPoint presentation, trainee post test and training evaluation, and trainee post-test answer key. We include an index to these modules in **Attachment E.**

These curricula/modules are available and implemented at the site level through our Program Manager and select staff. We supply each of our distinct contracts with copies of the modules and routinely add new modules and update existing modules. The frequency at which we provide these training modules varies by contract. In some contracts, our training modules are used as part of new-employee orientation for security, medical, and administrative staff and provided on a regular, routine basis. We also provide train-the-trainer services to educate medical and administrative staff on delivering training to their staff on some of the topics above.

Training needs are identified by program managers, medical directors, and clinical directors and as an outcome of our quality assurance, utilization review, and auditing procedures. Each program is able to call upon the resources of our corporate Clinical Operations Department to provide training or to assist in the development of training programs for staff. Every month, all of our medical directors have a conference call led by our Vice President of Clinical Operations, Dr. Jane Haddad. In this call, training needs

are routinely discussed and training programs are developed.

Upon contract award, MHM will submit the developed training curriculum for review by the DDOC. We will collaborate with the DDOC in tailoring the correctional officer training to the system's needs and will develop an annual schedule for correctional officer training. Similarly, we will collaborate with the DDOC and the medical vendor to establish a training program and schedule for medical staff.

Training: Pharmacy Management

Psychiatrist educational and training presentations are led by our pharmacists at the psychiatrist meetings on a monthly, rotating basis.

MHM's pharmacists participate in frequently held company-wide or contract-specific conference calls and company-wide conferences held twice a year (Spring Medical Directors Conference and Fall MHM Annual Conference). Between these events, the Pharmacy Management Department provides all Medical Directors valuable information from numerous peer reviewed sources as it is published. Medical directors for each program then disseminate this information to psychiatrists in their programs.

Examples of our training programs are provided in **Attachment A**. These include the Psychiatrist Education and Training Presentation and the Vermont Pharmacy Orientation.

Training: Leadership

We provide a number of programs for MHM Leadership. We believe effective leaders assist MHM to meet and exceed our client expectations. An example of our Leadership Management Development Program content is included over the following pages.

Leadership Management Development Program
BEING OUT OF THE BOX: Often times we make assumptions about others that "block" us in our ability to be effective with our interactions with them. This program is designed to provide dialogue that works to identify this dynamic and offer techniques that enable us to step out of our self-imposed boundaries. It is a subject area that should be applicable to the needs of all levels of staff. **BOUNDARIES:** The Correctional environment magnifies the ramifications of boundary violations when dealing with inmates, both in treatment and in everyday contact. This program reviews the expectations with specific examples of violations and consequences of them. It highlights what the staff member can do to minimize opportunity for violations to occur. This is an extremely vital training program that is applicable to the needs of all levels of staff. **CLIENT RELATIONS:** The fact that MHM contracts to provide the best in mental health care and treatment highlights the need to appreciate the role of the contractor/client in defining what form such treatment will take and what specific contractual obligations influence the provision of those services. This program has proven valuable to all levels of

Leadership Management Development Program

staff.

COMMUNICATION: Effective communication, both verbal and written, provides a continuous need for improvement for everyone. The associated challenges take many forms and are inevitably situational. Dealing with the ever changing dynamics benefits by a review of issues as well as seeking to add to the proverbial "toolbox" from which we can draw for each instance of application.

CONFLICT: Interpersonal conflict is an ever present element of our lives and the workplace is no exception. This program provides a focus for discussion around identifying and dealing with conflict. Indeed, intellectual conflict may be a very positive contributor toward effective performance if properly managed. This program is best suited to those who are faced with the responsibility of managing a workplace although it can be "customized" to benefit the needs of all levels.

CREATIVE THINKING: The expectation of producing more with less demands an examination of all possibilities. This program presents an array of practices that have been proven effective for "seeing in a new light". Those with leadership/management responsibilities would most benefit from this program.

DECISION MAKING: Our lives are filled with decision points. Fish or cut bait. This program seeks to provide "tools" that are intended to assist in reducing the risk of the wrong decision. While we all face the choice of getting out of bed, this program is aimed at those with management responsibilities.

GETTING RESULTS: Identifying what results are intended/directed is the first step toward assuring that they are achieved. Various processes are reviewed that address identification, process, and respective monitoring. Many levels of staff benefit from a review of these essential considerations.

HIRING: The objective of this program is to identify the key areas of focus when considering candidates for hire or promotion. Interviewing practices are reviewed. The target audience is those who are responsible for these decisions.

LEADERSHIP: This program is the core of the "Leadership Retreat" concept within which the practical and theoretical elements of leadership are reviewed. Literature and historical examples are utilized to review the basic styles of leadership. While leadership is a quality demonstrated and valued at all levels, this program is designed primarily for those with supervisory responsibilities.

MANAGEMENT: While leaders set the vision, it is up to the managers to make it happen in the most effective way. Considerations of processes and relationships form the core of discussion in this program, which is aimed at those with respective responsibilities.

MOTIVATION: Often times the greatest challenge to leaders and managers is to unlock the negative and dysfunctional mindsets that can develop among peers and staff. This program takes a look at the roles that we each play in the attitude of the workplace and how to be a positive influence on it. While this is of value to all, the primary audience is intended to be those with leadership/management responsibilities.

NEGOTIATION/PERSUASION: At the core of effective leadership and management is

Leadership Management Development Program
the ability to achieve identified goals. To this end, the arts of negotiation and persuasion are reviewed with the goal of developing associated strengths for those with leadership/managerial/supervisory responsibilities. **PERFORMANCE EVALUATION:** A core responsibility of those with supervisory responsibilities is the ability to effectively evaluate their own performance and those of others. Hand-in-hand with this skill is the responsibility of utilizing that evaluation to develop and strengthen the performance. This program seeks to build a deeper understanding of related processes. **PRESENTATION SKILLS:** This program reviews key elements of successful presentations, both verbal and written. While it addresses skills of value to all, it is intended for those whose leadership and management responsibilities include addressing the client and individuals outside of their direct reports and supervisors. **PROBLEM SOLVING:** Problems come in all shapes and sizes and with remarkable unpredictability. Discussion within this program seeks to build on abilities to be proactive in such a way that problems are addressed at the first possible moment if not prevented all together. Tools are reviewed for those frequent situations where, no matter what we do, there is the problem. These are issues important to all staff. **PROJECT MANAGEMENT:** Established methods of project management are reviewed with the goal of identifying strengths and weaknesses so that the appropriate style is aligned with the situational demands. This program would be useful to all staff who find themselves in a position of pursuing an identified project goal. **SUPERVISION:** Supervisory responsibilities often call upon knowledge that has not been available to those whose education has been built around clinical capabilities. This program reviews the basic expectations of supervision and addresses processes available to assist in the effective application. The program is directed to those with supervisory responsibilities. **TEAM BUILDING:** This program takes a look at the dynamics, positive and negative, that arise within work locations. Exercises and discussion focus upon steps to take that may facilitate creating and maintaining a healthy team, whether project or workplace specific. It is a program for everyone. **WORKPLACE RELATIONS:** A program for everyone, the focus is placed on the importance of being aware of the role that we each play in making the workplace the most effective for all. It seeks to identify those elements of positive and respectful interactions (whether with client, peers, supervisors, or reports) that facilitate productive performance.

Continuing Education

In addition to the training services mentioned above, we also incentivize employees to participate in continuing education activities and provide each employee with a continuing education allowance as part of our benefits plan. This allowance is helpful for licensed employees who must participate in certified continuing education programs to maintain licensure. We have also found this benefit helpful in reducing turnover and highly appreciated by our clinical staff.

C.4. Credentialing & Privileging of Professional Staff (Initial & Ongoing)

Each Vendor responsible for providing staff under this solicitation shall have a system for credentialing and privileging staff that is approved by the Bureau Chief. Each off-site service requiring licensure and certification in the State of Delaware used by any Vendor shall have that licensure or certification on file and be in good standing without practice restrictions. See DDOC Policy C01, Credentialing, for further information.

MHM acknowledges, accepts, and will comply with the above requirements.

We hire only professional candidates that meet MHM's credentialing standards promulgated by the State of Delaware and national organizations, pass agency background checks, and have final approval by the agency for hire.

MHM will strive to ensure that individuals recruited to provide clinical services in Delaware correctional facilities have the appropriate training and credentials to perform these services. Documentation establishes that reported licenses and credentials have been verified and that licenses/credentials remain current. MHM ensures that tasks that require oversight by a licensed practitioner receive such oversight.

MHM's Credentialing Process is consistent with the standards of the National Commission on Correctional Health Care (NCCHC) and the American Correctional Association (ACA). We provide a copy of our Credentialing Process in **Attachment F.**

C.5. Work Hours Required On-Site

A 40-hour week is full time. Meal breaks shall not be reimbursed. Credit for filling a post is given when an individual reports for duty at the facility to provide clinical service. Travel time is not considered as time worked with regard to the staffing hours.

All fulltime hours shall be spent on-site at a facility, except as is otherwise expressly agreed to in writing by the Bureau Chief. Vendor must supply written documentation detailing schedules which are not consistent with the 40 hour week. This might include the pharmaceutical, network or other Vendors. Facility staffing work schedules may be modified only upon prior written agreement between the DDOC BCHS and the Vendor. Each Vendor responsible for providing staff to the DDOC under this solicitation must obtain approval for any Vendor staff off-site training time. The maximum allowable training time per individual clinical staff member is 40 hours per year. Staff training planned for Vendor's non-clinical staff should be clearly presented in Vendor's response to this RFP. The DDOC will not count staff time in attendance at off-site meetings unless so authorized in advance by the DDOC BCHS.

MHM acknowledges, accepts, and will comply with the above requirements.

The training we offer is detailed above in *Section C.3.*

C. 6. GRIEVANCES & INQUIRIES/COMPLAINTS

Each Vendor will act on all complaints and inquiries received from the DDOC BCHS and others as directed by the DDOC Office of Health Services pertaining to health care-related problems, including a comprehensive written response to the complaint to assure the problems are addressed and resolved. The Vendor's policies and procedures must mirror those of the DDOC. The Vendor must comply with all DDOC offender complaint/grievance procedures as referenced in DDOC policy. The Vendor must utilize DACS for grievance initiation and follow-up communication.

Each Vendor will maintain comprehensive monthly information on all grievances filed and actions taken at each institution, in the format that is specified by the DDOC and provide monthly summaries as a part of the Monthly Health Services Report. The DDOC reserves the right to review any offender complaint and the Vendor's actions. The Vendor must implement DDOC recommendations in disputed cases. No additional costs to the DDOC will be permitted in such cases.

Additionally, each Vendor must provide timely investigation and reports for all complaints and inquiries. In all such cases, the DDOC has the final authority to resolve such complaints.

MHM acknowledges, accepts, and will comply with the above requirements.

We strongly supports offenders' rights to submit inquiries and grievances about their healthcare, and have a long history of utilizing grievances to identify systemic issues in service delivery that are in need of improvement. MHM has developed a Model Policy and Procedure for responding to offender concerns through an informal complaint resolution process and through the client's formal grievance resolution process. Upon contract award, this policy will be reviewed and tailored to be consistent with the DDOC Policies 11-A-11 and 4.4. Our policy will utilize the DDOC's grievance forms, and will provide a mechanism for offenders to request and receive assistance in completing concern and grievance forms. As with all other MHM policies and procedures, our grievance policy will be submitted to the DDOC BCHS for approval prior to implementation.

MHM is committed to ensuring that offenders have the opportunity to question their mental health care. During intake assessments and whenever an offender appears dissatisfied with the current treatment provided, offenders will be informed of their right to express their concerns, questions, and complaints regarding mental health services. We understand that the DDOC will make grievance forms available to all offenders in every housing unit.

Consistent with DDOC policy, offender complaints will be resolved informally whenever possible. MHM staff will consult with the Program Manager (Mental Health Administrator) or MHM Medical Director within one business day when a sick call request or offender interaction suggests that the offender is dissatisfied with services. This timely response is necessary to facilitate early intervention. The consulted supervisor will decide how best to address the offender's concerns. The MHM staff member reporting the offender complaint may be asked to meet with offender and document this intervention in a written response to the offender. If the staff member reporting the complaint is directly involved in the services being questioned, the mental health supervisor or designee will address the complaint. Copies of the written responses to offender complaints will be forwarded to the MHM CQI Manager for input into a centralized log for Resolution of Complaints and Grievances.

Attempts to resolve complaints informally will not be used to delay the grievance process nor restrict the offender's right to file a formal grievance. If the offender is dissatisfied with the informal complaint resolution process, he/she will be provided the formal grievance form authorized by the DDOC. MHM staff will collaborate with follow-up of formal offender grievances in accordance with the DDOC Policy and Procedures. MHM staff will respond to all formal grievances related to mental health services as clinically indicated and as directed by the Health Services Administrator (HSA).

We understand that formal grievances will be screened and tracked in DACS by the Institutional Grievance Chair, that the HSA will be responsible for investigating each grievance, and that a Medical Grievance Committee will review all unresolved grievances. MHM will support and cooperate with each of these processes. Upon receipt of a grievance related to mental health services, the Institutional Grievance Chair will enter the required information into DACS, and mental health staff will forward a copy of the grievance to the MHM CQI Manager. In the event that a formal grievance related to mental health services is not received directly by MHM staff but is sent to the designated institutional department, MHM will ask that the grievance is forwarded to the MHM CQI Manager and the Institutional Grievance Chair. The CQI Manager will log the receipt of the formal grievance following DDOC-approved documentation.

MHM will assist in investigating and addressing all complaints and inquires, and we will abide by the DDOC resolutions when disputes regarding treatment protocols or procedures arise during the course of addressing an offender's grievance. If the MHM Program Manager or Medical Director determines that the grievance is of a serious nature, involves multiple programs or staff members, or indicates a risk to the program, the Program Manager will meet with the offender following investigation of the grievance. Attempts to resolve the grievance will be documented in accordance with DDOC policies and forwarded to the relevant DDOC staff for review and distribution to the offender. A copy of the grievance resolution documentation will be forwarded to the MHM CQI Manager to facilitate tracking, and resolutions will be documented in DACS. We will maintain comprehensive data regarding grievances, and these data will be aggregated and reported on a monthly basis according to DDOC specification.

Comprehensive data regarding offender grievances will permit the CQI Manager and Institutional Grievance Chair to monitor the timeliness of MHM staff in response to the complaints/grievances. The log will be analyzed monthly with the results submitted to the CQI Committee. The CQI Manager will trend the types of complaints/grievances received over time to assess if the complaints/grievances are related to specific staff members or to identify the need for specific service improvements. These results will be routinely shared with the CQI Committee and discussed at MAC meetings.

C.7. POLICIES, PROCEDURES, & GUIDELINES/PROTOCOLS

Each Vendor will follow DDOC BCHS policies and procedures. Each Vendor will develop uniform policies, procedures and guidelines/protocols consistent across all institutions and facilities at the beginning of the contract. They must be submitted to the DDOC for approval within 90 days of contract award and must meet NCCHC standards and be consistent with DDOC policies and procedures. Each Vendor will provide the DDOC with a sufficient number of copies of their polices, procedures, protocols and guidelines as is necessary to supply DDOC administrators. All changes/revisions shall be supplied 30 days prior to the intended initiation of such changes/revisions and be approved by the BCHS. Copies of annual review sheets referenced in the NCCHC standards must also be supplied. All Vendor policies and procedures are subject to final approval by the DDOC.

MHM accepts, acknowledges, and will comply with the above requirements.

We will provide mental health services that comply with DDOC BCHS policies and procedures relevant to the mental health service delivery system. Our mental health services will comply with applicable state and federal laws and agreements with regulatory agencies including the Department of Justice.

As noted previously, MHM is committed to a mental health delivery system consistent with NCCHC standards. MHM has developed a Model Policy and Procedure Manual that addresses each NCCHC standard. When there are mental health issues such as mental health consultation to the disciplinary process that are not specifically addressed by the NCCHC, MHM has developed policies specific to these issues. Forms have been developed to implement each of these policies.

The MHM Model Policy and Procedure Manual is offered to provide guidance in developing site-specific policies and procedures that are consistent with the client's policies and procedures. When there is a variance between the MHM and client policies, the policy with the most stringent requirements will be recommended. Our preliminary review of the DDOC BCHS policies indicates that the goals and practices are consistent with MHM's model policies.

Upon contract award, MHM will begin the collaboration with DDOC BCHS to ensure that MHM has an accurate understanding of the DDOC policies and procedures and the

format in which the DDOC BCHS would like the site-specific mental health policies. We understand that the site-specific policies and procedures must be approved by the DDOC prior to implementation. We will submit both a hard and an electronic copy of the site-specific policies and procedures to the DDOC within 90 days of contract award. We also understand that, once approved, an annual review of each policy is required with subsequent revisions approved by the DDOC. Revisions required prior to the annual review due to changes in practice expectations will be also be submitted to the DDOC for approval prior to implementation.

Upon contract award, MHM will submit to DDOC BCHS the protocols that we have developed to assist our staff in providing consistent, quality mental health services. These protocols include Treatment Guidelines for our psychiatric staff and Clinical Guidelines for our mental health staff. These guidelines will be modified to meet the unique requirements of the DDOC.

MHM does not restrict the prescribing practices of psychiatric staff; however, MHM Treatment Guidelines are provided for the mental disorders common to corrections. If psychiatric staff order medication outside of the Treatment Guidelines, they are expected to provide clinical justification for the decision in the offender's medical record. Further, if psychiatric staff order medication outside of the system's formulary, they must receive approval from the MHM Medical Director through the non-formulary request process.

MHM's Treatment Guidelines were developed and are continually refined by the MHM Medical Directors to ensure MHM psychiatric staff are aware of current standards of practice. The MHM Treatment Guidelines were initially based on guidelines of national organizations, including the American Psychiatric Association and the Texas Medical Algorithms Project. The Treatment Guidelines were further honed by the MHM Medical Directors after researching peer reviewed literature to gain an understanding of the other applications of similar guidelines with special attention to comparing efficacy and side effects. At least annually, the Treatment Guidelines are also reviewed based on the standards of correctional mental health, experience, and a national network of mental health providers.

MHM is fortunate to have two pharmacists, Gregg Puffenberger, PharmD, MBA, and Vince Grattan, RPh (see *Tab 2, Section III, B.1*), to ensure that our Medical Directors have the most current psychopharmacology information available to make informed decisions about their practices and the Treatment Guidelines. Monthly conference calls and annual meetings provide a forum for problem-solving and the sharing of information between the Medical Directors.

Benefits of the Treatment Guidelines include the following:

- Consistent offender care and improved offender compliance with treatment recommendations
- Assurance that the community standard of care is provided
- Reduced legal risk

- Cost savings related to the advantage of purchasing medications in higher volumes because use is more consistent and predictable
- Cost savings from reduced polypharmacy and off-label prescribing

Treatment Guidelines for the following disorders were developed, reviewed and/or revised by the MHM Medical Directors in May of 2009:

- Psychotic Disorders
- Depressive Disorders
- Bipolar – Depressive Episode
- Bipolar – Manic Episode
- Bipolar-Maintenance
- Anxiety Disorders
- Adult Attention Deficit and Hyperactivity Disorder
- Posttraumatic Stress Disorder

We have also developed guidelines for laboratory testing and additional monitoring for side effects of psychotropic medications. Treatment Guidelines to assist in the evaluation and treatment of Dementia and Tardive Dyskinesia are currently being finalized.

While the MHM Treatment Guidelines provide strategies for prescribing psychotropic medication, each guideline includes the statement: "*Treatment guidelines do not replace sound clinical judgment nor are they intended to strictly apply to all patients*." Each MHM Medical Director has the opportunity to modify the treatment guidelines for a specific contract to be consistent with the system's formulary and/or preferences. Modifications are reviewed by the MHM Medical Directors to ensure the revisions are clinically appropriate.

MHM's Clinical Operations Department has been working with our psychologists in response to their requests to develop Clinical Guidelines for various mental health services required by the NCCHC and for specialized mental health services that are commonly needed in correctional settings. The Clinical Guidelines developed to-date include protocols for the following required NCCHC practices:

- Psychological Reconstructions (autopsies)
- Critical Incident Stress Debriefings (separate Guidelines for debriefing offenders and debriefing affected staff)
- Competency to make Medical Decisions
- Initial Segregation Evaluation

Two additional Clinical Guidelines that have been developed for challenging mental health services in correctional settings are as follows:

- Providing Mental Health Consultation to the Disciplinary Process
- Developing and Implementing Behavior Management Plans

The latter Guidelines support MHM's initiative to increase staff expertise in behavior management principles and interventions. Additional Guidelines are currently under development and anticipated to be finalized before the start of the contract.

As previously noted, MHM understands that all mental health policies and protocols must be approved by the DDOC BCHS. Our first goal will be to comply with the DDOC's current policies. Policies, procedures, and protocols from MHM's internal clinical infrastructure will be offered to assist in any refinement of the system as requested by the DDOC.

C.8. Continuous Quality Improvement

Each Vendor shall have a written continuous quality improvement system showing the continuous emphasis on quality it dedicates to all programs and services provided. The program shall be evidence based, i.e., it shall be supportable by data collected and compiled by the Vendor on all service areas it provides under this contract. While utilization plays a role in the efficiency of services provided, quality indicators in the form of Outcome Measures must be established in coordination with the DDOC to assure both efficiency and quality. Each Vendor will work with the DDOC through its quality committee to develop a common form, format, and schedule for quality improvement reporting to ensure a system and tools for monitoring Vendor's efficiency, effectiveness, and quality of services. Monthly reporting to the Bureau Chief is mandatory and must be received prior to the Vendor receiving payment for the reporting month. The goal is to assure adequate access to care for offenders with serious medical illness, to improve offender outcomes, and to meet NCCHC standards.

MHM acknowledges, accepts, and will comply with the above requirement.

MHM is committed to ensuring the implementation of a strong quality improvement process. We have extensive experience developing and implementing quality improvement programs that meet NCCHC requirements. MHM will cooperate with the implementation of the DDOC's Continuous Quality Improvement (CQI) program as well as the CQI program of the medical provider. We will be active participants in the CQI programs conducted system-wide and at each facility and will collect all information and statistics requested. To complement the DDOC's and the medical provider's CQI programs, MHM will also conduct an internal CQI program in which mental health issues are the primary focus. Findings and recommendations from the MHM CQI program will be regularly shared with the other CQI programs.

MHM has developed a Model CQI program that includes the structure of the CQI Committee, the types of studies to be conducted, and an annual peer review process. Upon contract award, MHM will collaborate with DDOC BCHS in tailoring the MHM CQI program for the DDOC contract. We will ensure that the measures requested by the DDOC are regularly monitored and reported in the format requested by the DDOC.

We understand that the DDOC multidisciplinary CQI program must review the following service areas on an annual basis:

- Access to care
- Receiving screening
- Health assessment
- Continuity of care, including
  - Sick call
  - Chronic disease management
  - Discharge planning
- Infirmary care
- Nursing care
- Pharmacy services
- Diagnostic services
- Mental health care
- Dental care
- Emergency care and hospitalizations
- Adverse patient occurrences including all deaths
- Critiques of disaster drills
- Environmental inspection reports
- Inmate grievances
- Infection control

While some of these areas will fall outside of MHM's scope of service, MHM will collaborate with other vendors and the DDOC in conducting CQI reviews when the areas involve MHM service delivery. We will also conduct independent CQI studies for mental health and substance abuse services.

CQI Committee

The MHM CQI program is overseen by a multi-disciplinary CQI Committee chaired by the MHM Medical Director, and activities of the CQI program are facilitated by the MHM CQI Coordinator. The MHM CQI Committee meets no less than quarterly and is attended by the MHM Program Manager, representatives from the psychiatric staff, and mental health clinicians. Representatives from the administrative, security, and medical staff are invited to participate.

The primary purpose of the MHM CQI Committee is to identify problems and opportunities for improvement based upon the data collected in the monitoring process, including from inmate grievances. As part of the program, a major occurrence report is initiated for completed suicides, serious suicide attempts that require off-site or infirmary medical care, and deaths of inmates receiving mental health services. The MHM Medical Director or designee reviews all completed suicides and serious suicide attempts within five working days of the event. More comprehensive mortality reviews of suicides, including review of NCCHC-required psychological reconstructions (autopsies) completed by qualified mental health clinicians, are conducted in MHM CQI Committee meetings.

MHM's commitment to quality improvement is demonstrated by the designation of a CQI Coordinator in each of our contracts. As noted previously, a comprehensive manual has been developed for the orientation of new CQI Coordinators to the quality improvement process within the correctional environment. MHM CQI Coordinators receive ongoing support and training through monthly conference calls and annual meetings. A training program has been developed to orient all MHM staff to the goals, methodology, and tools used in ongoing quality improvement efforts. The expectation that MHM clinical staff actively participate in the CQI program is included in all job descriptions.

Outcome Measures

MHM's commitment to providing mental health services based on evidence of successful outcomes is demonstrated by the initiation of company-wide outcome measures. Collecting consistent data from all of our contracts permits MHM to evaluate outcomes from a broad base, nationwide. Our CQI Coordinators submit data to MHM's centralized Clinical Operations Department for analysis. MHM's company-wide initiative to analyze factors in suicides and serious suicide attempts was first initiated in 2007. Data has been collected and analyzed without identifying the specific clients. We currently have a sample that permits meaningful analysis and are continuing to collect data for this project.

During 2009, MHM initiated two additional company-wide initiatives studying treatment outcomes. MHM provides our mental health staff with curricula and materials that enable them to conduct standardized group psychoeducational treatment with caseload inmates. We have developed content-specific pre- and post-tests for each group and have begun collecting pre- and post-group test data to measures the clinical effectiveness of the groups in fostering offender change. To date, we have collected several hundred pre- and post-group outcome tests. Also during 2009, MHM began assessment of the outcomes of the Taking a Chance Program, the in-cell programming for offenders restricted to segregation units (see *Tab 5, Section IV, g*). We are now collecting pre- and post-program data measuring criminal thinking styles. Clinical Operations staff have expertise and advanced training in the use of the SPPS program for the statistical analysis of outcome data. The outcome data will be made available to MHM's clients and will assist in refining the programming offered to DDOC offenders. For further information on CQI, please see *Tab 3, 4, vii.*

C.9. Morbidity & Mortality Review

(See requirements in DDOC Policy A-10. 1, Morbidity and Mortality Review)
Each Vendor providing on-site clinical staff must provide clinical participation in the DDOC Morbidity and Mortality Review Committee meetings consistent with DDOC Policy and NCCHC Standards.

MHM acknowledges, accepts, and will comply with the above requirements.

We will collaborate with all required elements of the Morbidity and Mortality Review process as set forth in DDOC Policy A-10.1. MHM supports NCCHC standards requiring such reviews and considers Morbidity and Mortality Reviews and associated Psychological Autopsies for offender suicides to be part of the CQI Program. We have developed specific policies, procedures and guidelines to support this process. Upon being awarded the contract, MHM will begin working closely with the DDOC BCHS to align these policies and guidelines to the DDOC's specifications.

As noted above, MHM's CQI program requires that a major occurrence report be initiated for completed suicides, serious suicide attempts that require off-site or infirmary medical care, and deaths of offenders receiving mental health services. The MHM Medical Director or designee reviews all completed suicides and serious suicide attempts within five working days of the event. In finalizing the review of completed suicides, the offender's mental health and medical records are reviewed and mental health staff, medical staff, correctional staff, and/or inmates are interviewed. Mortality reviews will be conducted in Morbidity and Mortality Committee meetings pursuant to DDOC policy. In other contracts, MHM's participation in Morbidity and Mortality reviews has assisted the client in coming into compliance with Department of Justice standards.

Because the processes for completing Psychological Autopsies are relatively unique to correctional environments, MHM has developed Clinical Guidelines and a comprehensive Interview Guide to support this process. These documents serve as a resource for staff who are assigned responsibility for Psychological Autopsies. It is MHM's recommendation that Psychological Autopsies are completed by independently licensed clinical psychologists who have extensive experience providing mental health care in correctional environments and who were not directly involved in the offender's treatment. Because Psychological Autopsies require considerable care and time, MHM will work closely with the DDOC BCHS to determine how best to staff and allocate time for this task.

C.10. Post-Critical Incident Review

Each Vendor must participate in the DDOC post-critical incident review process as defined in DDOC policies.

MHM acknowledges, accepts, and will comply with the above requirement.

MHM will collaborate with the DDOC in post-critical incident reviews as defined in DDOC policies. Our clinical leadership, including MHM's Program Manager and Medical Director, will participate in post-incident critical reviews as they are convened by the DDOC. We have extensive experience in such reviews, as we participate in multidisciplinary review committees in every contract where we provide services. Post-critical incident reviews may take the form of morbidity and mortality reviews, review of adverse medication events, business case modeling, or root cause analyses. We have developed training and procedural infrastructure to support staff with these processes. We are strong advocates for self-critical reviews and transparency in our findings, particularly

following critical incidents, and view these processes as essential for quality improvement. MHM understands that the DDOC's Adult Correction Healthcare Review Committee reviews all critical incidents, and we will provide all information as requested by the DDOC.

C.11. Risk Management

Risk Management is an essential administrative adjunct component to a clinical CQI system. Data from CQI activities, Morbidity and Mortality Review, and Post-Incident Review must be analyzed to review issues and determine trends that would suggest opportunities for improvement. Each Vendor shall work with the DDOC BCHS to develop and supply these reports. Reports should be free of individual offender identifiers and be used for the purpose of rapid problem identification and resolution following a business case scenario.

MHM acknowledges, accepts, and will comply with the above requirements.

We strongly support the DDOC's requirement that each vendor participate in risk management studies following findings from CQI studies, Morbidity and Mortality Reviews, and Post-Incident Reviews. Our staff have extensive experience in risk management, both at a clinical level and administrative level. On a company-wide basis, MHM's Clinical Operations Department participates in a Risk Management Committee. The Risk Management Committee reviews crucial elements of service delivery and ensures that we are proactively addressing areas of risk. Contemporary utilization of root cause analyses includes such a proactive approach, and MHM is eager to work with the DDOC to reduce risk before critical incidents occur.

Following adverse outcomes, MHM will also collaborate with the DDOC BCHS in developing analyses of incidents that identify key points of risk and solutions for reducing these "risk" points. Our collaboration will include participating in the preparation of required reports while ensuring that individual offender identities have been removed. The work completed under risk management will follow a careful business case scenario or modeling approach, so that the underlying processes and the system responses to critical incidents are well understood. This approach will permit MHM and the DDOC BCHS to develop system improvements that can prevent the reoccurrence of similar incidents.

C.12. Informed Consent/Right to Refuse Treatment

To assure that the offender receives the material facts about the nature, consequences and risks of any proposed treatment, examination, or procedure and the alternatives to the same, a written informed consent will be obtained according to DDOC Policy, using DDOC forms.

In every case in which the offender, after having been informed of the condition and the treatment prescribed, refuses treatment, the refusal must be in writing according to DDOC Policy, using DDOC forms.

MHM acknowledges, accepts, and will comply with the above requirements.

We will implement the DDOC policy and forms to document informed consent and an offender's refusal of treatment. MHM is familiar with and supports these principles through our Model Policies and Procedures which address these practices. In providing mental health services, informed consent and refusal of treatment issues are typically raised when prescribing psychotropic medication and when an offender refuses to take a medication that is necessary for the offender to maintain adequate functioning.

MHM understands the importance of obtaining informed consent prior to the initiation of psychotropic medication. MHM's Medical Directors have developed a guideline regarding informed consent and options for documenting informed consent. Some contracts prefer a generic form with psychiatric staff expected to specify on the form what the relevant benefits, risks, and alternatives to the specific medication are; other contracts prefer a form for different classes of psychotropic medication (e.g., first generation antipsychotics, second generation antipsychotics, mixed action antidepressant medications, etc.); and others prefer a consent form for specific medications. Consent forms for each of these options are available for implementation. Upon contract award, we will collaborate with DDOC BCHS to determine the approach that is preferred by the DDOC. Further, the informed consent forms will be tailored to meet the specific requirements of the DDOC.

As noted previously, MHM is a strong supporter of the *Harper* court decision that permits offenders to receive involuntary psychotropic medication when the criteria for involuntary medication under *Harper* are met and the required administrative review is conducted. The use of involuntary medication often improves an offender's quality of life and reduces behavioral incidents without the need to transfer the offender out of the system. We have extensive experience with the *Harper* administrative review process and will implement and follow the process in accordance with DDOC policy.

C.13. TELEMEDICINE EXPANSION

The DDOC sees advantage in the implementation of a telemedicine system for certain applications to provide faster access to care at remote facilities and to reduce the number of off- facility visits that generate substantial security costs and pose some risk to the community. Any Vendor who wishes to include a base station and remote stations as part of their plan for offender care should provide a complete written plan including the physical plant specifications required, and the equipment the Vendor will purchase to implement the system. In advance of implementation the DDOC Office of Health Services, in conjunction with the Department of Technology and Information, must approve any proposed telemedicine program. It is intended that telemedicine be used appropriately so that it does not affect the quality of care provided to the offender. The Vendor must be specific on the plans, protocols, and specialty services intended to be included in the plan.

MHM has included telepsychiatry as part of our proposal, see *Tab5, Section IV, u.*

C.14. RECORDS & REPORTS

The DDOC maintains an electronic tracking system which contains health care elements called DACS. Vendor's staff is responsible for timely entry of information on the system. Monthly Health Services Reports whose form and format are to be defined by the DDOC (including utilization data, risk management, and quality improvement activity summary reporting, etc. are to be completed by the Vendor each month and provided to the Bureau Chief in the form and format proscribed by the DDOC. The DACS data entry must be timely and, the Reports must be received by the 10th of the month for the preceding month, before any monthly payments to the Vendor will be released.

MHM acknowledges, accepts, and will comply with the above requirements.

We will ensure that our staff fully utilize the Delaware Automated Clinical System (DACS) since this system facilitates the provision of service delivery statistics required by the DDOC. As noted previously, our staff have experience with web-based offender information systems and utilize automated information systems in most contracts where MHM provides correctional mental health care.

MHM will provide the DDOC BCHS monthly reports regarding utilization data, risk management, quality improvement activities, inmate grievances related to mental health, and other areas required by the DDOC. We understand that the monthly reports are to be submitted to the DDOC BCHS by the 10th of the month for the preceding month and in the format designated by the DDOC.

Upon contract award, MHM staff will review the monthly reporting format with relevant DDOC staff to ensure that we fully understand the intent of each item on the form and how the DDOC would like the data collected. This process will facilitate total compliance with the DDOC's expectations. We are confident that we have included adequate clerical and/or data entry staff to support the MHM Mental Health Administrator in completing the monthly reports and other reports requested by the DDOC.

C.15.RESPONSE TEAM

Vendors will be a participating member of the DDOC's response team that provides and participates in post trauma incident debriefings and counseling services for critical incidents including disaster and pandemic episodes. Services will be provided both on- and off-facility to the Vendor and DDOC staff. Sessions are to be attended simultaneously by all DDOC and Vendor employees involved. These Response sessions are intended to expedite the recovery process, help foster a better understanding of the roles and traumas each person suffered, aid in recovery,

and promote a better understanding and appreciation for the roles played by the DDOC and Vendor employees.

MHM acknowledges, accepts, and will comply with the above requirements.

Designated and credentialed MHM staff will participate in the DDOC's response team for critical incident debriefing and counseling. Recognizing the need for critical incident debriefing, MHM has developed Clinical Guidelines to support designated staff in providing critical incident debriefing. These Guidelines are separate for debriefings involving staff and debriefings involving offenders, and promote compliance with the relevant NCCHC standard.

Affected personnel will have the opportunity to receive critical incident debriefings following disasters, pandemic episodes, suicides, and serious attempted suicides. MHM applauds the DDOC's approach of providing critical incident debriefing to both state and vendor staff. Both our experience and existing research have indicated that group debriefings may be less effective (and may in fact be harmful) in some circumstances. While our Clinical Guidelines are suitable for group debriefings, they can be adapted to individual debriefings when a group setting is not feasible or participation in a group raises concerns for the employee.

If awarded the contract, MHM will work closely with the DDOC BCHS leadership to develop policies and procedures to facilitate the infrastructure for the critical incident debriefing team and ensure that staff are properly credentialed before participating in the debriefing team. It will be critical to have sufficient numbers of staff credentialed so that debriefing can be provided to all affected personnel without requiring staff who have been involved in the critical incident to participate in the debriefing team.

C.16. Cooperative Interaction with Other Vendors

Each Vendor shall work cooperatively with any and all other health care Vendor(s) selected by the DDOC to provide comprehensive services to DDOC offenders such that access to care, continuity of care, and quality of care are maintained. Administrators and Clinicians will participate in such standing and ad hoc committees to coordinate Vendor activities as is determined necessary by the Bureau Chief.

MHM acknowledges, accepts, and will comply with the above requirements.

In virtually all of our correctional contracts, we work alongside a separate medical vendor in addition to other vendors, including pharmacy and dental vendors. MHM has extensive experience in collaborating with security staff, medical staff, state-employed mental health staff, substance abuse treatment staff, the pharmaceutical provider, and community agencies. We pursue such collaboration in all of our contracts whether the stakeholders are state employees or other healthcare vendors. We understand how essential such

collaboration is to the provision of quality mental health care and the prevention of adverse events.

Because the MHM program fosters teamwork and collaboration within our own ranks, we have found this environment often "invites" other offender health service vendors into greater collaboration with us. We also consistently reach out to collaborate with other health service vendors, since quality mental health services are dependent upon multidisciplinary communication and cooperation. Because such collaboration is critical in the provision of integrated substance abuse-mental health treatment, MHM is proposing to provide services to meet both needs. Discussion of our proposed integration of substance abuse and mental health services can be found in *Tab 2, Required Information* and *Tab 6, Substance Abuse.*

Collaborative relationships are further developed though participation in institutional meetings with administrative staff, monthly audit committee meetings with medical staff, the pharmacy and therapeutics committee, and CQI meetings of all disciplines. Open communication at these meetings permits discussion of systemic issues.

Multidisciplinary Meetings/Training

As a specialty vendor of behavioral health services within larger correctional medical programs, MHM succeeds at closing communication gaps and fostering cohesive multidisciplinary teams. In several of our contracts, the implementation of multidisciplinary meetings with facility administration, medical staff, and mental health staff has proven effective in facilitating the coordination of services, particularly for offenders that present management as well as health issues. MHM provides staff training in multidisciplinary sessions, and we have found that these training sessions – in addition to imparting important information – provide a crucial opportunity for networking and teambuilding across contract and non-contract staff. Conducting training with medical and custody staff, particularly when there is change in practice or a new program is being implemented, is helpful in sharing ideas and achieving agreement about staff roles and expectations.

We will take a proactive role in establishing collaborative relationships with other DDOC healthcare vendors. Upon contract award, MHM will schedule meetings with each healthcare vendor to ensure that we understand current or proposed practices and the expectations for MHM staff. Our goal will be to provide a seamless transition in services that precludes gaps in offender care and misunderstandings among the staff. MHM has found that open communication about challenges as well as opportunities in contract implementation builds the partnerships that permit the development of a quality mental health delivery system.

Accountability

The mental health and substance abuse program managers will be responsible to ensure MHM staff are collaborating with onsite staff, to participate in regularly scheduled meetings with other contractor administrative staff, and to engage in problem-resolution

when issues arise. MHM staff will be expected to report site-specific issues to the appropriate MHM program manager for his/her input and guidance.

MHM regional and corporate staff will routinely meet with DDOC and other vendor administrative staff to determine areas of satisfaction and areas for improvement. They will also routinely visit the sites in which MHM provides services to assess facility-based client and MHM staff satisfaction.

Joint Treatment Planning

MHM will establish informal as well as formal communication with the medical provider to promote an on-going cooperative relationship. The mental health Program Manager will be responsible for establishing routine lines of communication and developing procedures to ensure that ongoing coordination of services occurs. Further, the MHM Medical Director will maintain open communication with the healthcare services Medical Director for joint problem-solving of clinical issues. When an offender has both mental health and medical issues or is experiencing a terminal illness, MHM staff will participate in joint treatment planning with the medical staff in order to meet the needs of the "whole person."

Collaboration: Pharmacy Management

Gregg Puffenberger, PharmD and MBA, MHM's Director of Pharmacy Management, will develop cooperative relationships with the pharmaceutical provider to facilitate access to pharmacy information. This information is analyzed to identify trends in prescribing practices of the system, specific sites, and specific psychiatric staff. These analyses are shared with the client, MHM staff, and the pharmaceutical vendor.

Dr. Puffenberger will immediately contact the pharmacy vendor to determine the types of pharmacy information that will be available. Our goal will be to establish the process needed to generate pharmacy reports we use to analyze and monitor prescribing practices. As noted previously, the analyses permit review of system-wide psychotropic prescribing practices, facility-specific practices, and provider-specific practices. MHM has found that these analyses are useful for the pharmacy vendor as well as for the client.

MHM anticipates that the MHM Medical Director will be permitted to participate in the DDOC Pharmacy and Therapeutic (P&T) committee meetings. Dr. Puffenberger will also participate in the P&T committee when requested. His participation has proven helpful when changes in the psychotropic formulary are being considered and/or when there have been significant changes in psychotropic prescribing practices. In this role, he is able to share the most recent research on psychotropic medication to assist in making formulary decisions.

Effective interface between medical and mental health staff is particularly critical with the processes of medication administration and laboratory testing related to psychotropic medication. MHM's goal will be to develop a full understanding of the medication

administration and laboratory testing processes and how best MHM staff can interface with these processes.

TAB 5: MENTAL HEALTH SERVICES

At the end of this tab, we have supplied our staffing plan and a table that delineates the NCCHC standard(s) and DDOC policy and procedure(s) that apply to each mental health requirement, demonstrating our commitment to compliance with the intent and content of the RFP.

SECTION IV: MENTAL HEALTH SERVICES

The Vendor shall be responsible for administrative efficiency, quality, and cost-effectiveness of mental health services. The Mental Health Services Vendor shall be available to confer with the Bureau Chief at any time given sufficient notice concerning any provisions of this Agreement, any proposed changes in the Agreement, or any other matter pertaining to the performance of the contract.

MHM acknowledges, accepts, and will comply with the above requirements.

As with all of our clients, our goal upon contract award will be two-fold: (1) to enhance the quality of services and programs provided and (2) to lower costs through increased efficiencies. Additionally, we are confident that the integration of mental health services and substance abuse treatment services by the same vendor will significantly improve the treatment of offenders who have co-occurring disorders. Upwards of 80% of offenders with mental health needs also require treatment for substance abuse. Integrated mental health and substance abuse treatment is the model of choice for these offenders, and the provision of these services by a single vendor will greatly facilitate coordination of such treatment.

We recognize the dual impact of continued growth in the offender population and the realities of budget constraints driven by the difficult economic times. MHM will provide a leadership approach that offers long-term consistency and sensitivity to what we believe will be sustained budget pressures affecting our economy and the State of Delaware's correctional system. MHM will demonstrate our *proven* ability to provide cost-effective and reality-based services including:

MHM is proud of the services provided by our psychiatric staff company-wide. We currently employ close to 200 psychiatrists, two-thirds of which are board certified. In most of our contracts, nurse practitioners assist in providing psychiatric services. We have found these staff to be excellent clinicians and the use of nurse practitioners is a cost-effective way to expand the availability of psychiatric services. With the approval of the DDOC, we would explore the potential of using nurse practitioners to supplement our psychiatric staff.

MHM psychiatric staff are expected to comply with the client's standard operating procedures related to psychiatric practices. MHM policy requires them to complete an initial psychiatric evaluation whenever an inmate is referred for services. The referral may be generated by the reception process, mental health staff, medical staff and/or

security staff. In completing the psychiatric evaluation, the psychiatric staff are expected to review the inmate's medical records as well as reports of prior psychiatric treatment, if available. If the psychiatrist believes access to prior psychiatric records that are not available would be helpful in on-going treatment, the psychiatrist is expected to request these records.

Standardized forms have been developed for conducting initial psychiatric evaluation to ensure that the psychiatrist completes a comprehensive assessment. The form requires a brief psychiatric and psychosocial history, DSM 5 Axis diagnosis, target symptoms supporting the diagnosis, and treatment recommendations. As noted above, MHM psychiatric staff begin the treatment planning process during the initial psychiatric evaluation. Our psychiatric staff are expected to be active members of the multidisciplinary treatment teams. When psychiatric presence at a treatment team meeting is not possible due to scheduling issues, the psychiatric staff will be available for consultation and will review and approve the treatment plans.

Treatment Guidelines

MHM does not restrict the prescribing practices of psychiatric staff; however, MHM Treatment Guidelines are provided for the mental disorders common to corrections. If psychiatric staff order medication outside of the Treatment Guidelines, they are expected to provide clinical justification for the decision in the inmate's medical record. Further, if psychiatric staff order medication outside of the system's formulary, they must receive approval from the MHM Medical Director through the non-formulary request process. The MHM CQI program routinely reviews compliance with Treatment Guidelines and the non-formulary request process.

MHM's Treatment Guidelines are developed by the MHM Medical Directors to ensure MHM psychiatric staff are aware of current standards of practice. The MHM Treatment Guidelines were initially based on guidelines of national organizations, including the American Psychiatric Association and the Texas Medical Algorithms Project. The Treatment Guidelines were further developed by the MHM Medical Directors after researching peer reviewed literature to gain an understanding of other applications of similar guidelines with special attention to comparing efficacy and side effects. The Treatment Guidelines are also reviewed based on the standards of correctional mental health, experience and a national network of mental health providers.

Treatment Guidelines for the following disorders were developed, reviewed, and/or revised by the current MHM Medical Directors in April of 2009: Psychotic Disorders; Depressive Disorders; Bipolar – Depressive Episode; Bipolar – Manic Episode; Bipolar-Maintenance; Anxiety Disorders; Adult Attention Deficit and Hyperactivity Disorder; and Post Traumatic Stress Disorder. Treatment Guidelines to assist in the evaluation and treatment of dementia and tardive dyskinesia are currently being developed.

While the MHM Treatment Guidelines provide strategies for prescribing psychotropic medication, each guideline includes the statement: "Treatment guidelines do not replace sound clinical judgment nor are they intended to strictly apply to all patients." The MHM Medical Director has the opportunity to modify the treatment guidelines for a specific contract to be consistent with the system's formulary and/or preferences. Modifications are reviewed by the MHM Medical Directors to ensure the revisions are clinically appropriate.

Medication

MHM psychiatric staff are not to order non-psychotropic medication unless the medication is necessary to manage side effects. Our psychiatric staff will refer inmates with medical conditions potentially requiring medication to the medical staff. MHM psychiatric staff are expected to minimize orders for lay-ins, bottom bunks, transfers, and snacks.

MHM understands the importance of obtaining informed consent prior to the initiation of psychotropic medication. The MHM Medical Directors recently finalized a guideline regarding informed consent and developed options for documenting informed consent. Some contracts prefer a generic form with psychiatric staff expected to complete the benefits/side effects of the specific medication on the form; other contracts prefer a form for different classes of psychotropic medication; and others prefer a consent form for specific medications. Consent forms for each of these options are available for implementation of the approach best suited for the system.

With respect to psychiatric treatment, MHM is a strong advocate of the use of involuntary medication as approved by the Supreme Court *Harper* decision for offenders who refuse the medication necessary to address their mental illnesses. Although proceedings under *Harper* do not require an explicit finding that the offender lacks capacity to make informed medical decisions regarding his or her psychiatric treatment, impairments in capacity are almost always present in these cases. When attempts to persuade offenders to voluntarily accept psychotropic medication fail, it is usually because the offender's capacity to make informed medical decisions is impaired. It is MHM's position that impairments in decision-making should not prevent an offender from receiving treatment when criteria for involuntary medication under *Harper* are met. The use of involuntary medication often improves an offender's quality of life and reduces behavioral incidents without the need to transfer the offender out of the system.

MHM staff will complete mental health assessments required under the DDOC's procedures for non-emergency involuntary medication administration, and psychiatric staff will participate in involuntary medication proceedings. We have extensive experience with the *Harper* administrative review process based on current contracts. Typically, the MHM Medical Director provides the leadership for the involuntary medication reviews unless he/she is the referring psychiatrist. In those instances, another psychiatrist from the system provides the leadership for the administrative review. Based on our experience, the leadership and oversight of the *Harper* administrative review

process may be provided through the telepsychiatry network or a conference call. In all cases, the review process is audiotaped for the record.

When an inmate is initially prescribed a psychotropic medication or there has been a change in medication, psychiatric staff provide the follow-up that is clinically indicated. Once an inmate has adequately adjusted to the medication, routine follow-up will be scheduled no less than every 90 days. In special cases, such as inmates on involuntary medication status, youthful inmates, or inmates exhibiting elevated stress or potential deterioration, psychiatric monitoring will be completed more frequently. Inmates who refuse medications that the psychiatric staff think is necessary for stabilization continue to receive mental health/psychiatric follow-up.

MHM psychiatric staff are expected to order and review laboratory testing required at the initiation of psychotropic medication and periodically thereafter. Abnormal Involuntary Movement Scales (AIMS) testing is conducted no less than every six months when inmates are prescribed an antipsychotic medication. The MHM Medical Directors have developed laboratory testing guidelines related to the monitoring of atypical antipsychotics and other psychotropic medications requiring routine laboratory testing. The MHM Medical Director of a contract may modify these guidelines based on the preferences of the system.

The MHM Medical Director is responsible for the oversight and clinical supervision of psychiatric staff. These responsibilities include the implementation of annual peer review process and monitoring of psychotropic medication prescribing practices. The contract's Medical Director is supported in these duties by the MHM Director of Pharmacy Management, Gregg Puffenberger, PharmD, and other MHM Medical Directors.

Dr. Puffenberger assists MHM Medical Directors in staying abreast on psychotropic medication issues by reviewing the literature and providing relevant information. He also collaborates with the pharmacy provider to ensure that the pharmacy reports required to monitor and effectively manage prescribing practices are available and analyzed for the contract's Medical Director and the client. The analyses permit review of system-wide psychotropic prescribing practices, facility-specific practices, and provider-specific practices. MHM has found that this support for the Medical Director in managing the use of psychotropic medication has been very effective. MHM anticipates that the MHM Medical Director will be permitted to participate in DDOC Pharmacy and Therapeutic (P&T) committee meetings. Dr. Puffenberger will also participate in the DDOC P&T committee when requested. His participation has proved helpful when changes in the psychotropic formulary are being considered and/or when there have been significant changes in psychotropic prescribing practices. For further information regarding MHM's Pharmacy Management Program, see *Tab 2, Section III, B.1*.

Support

Support for each of our Medical Directors includes monthly conference calls and annual meetings with the MHM Medical Directors. During these meetings, company-wide

guidelines reflecting psychiatric best practices are reviewed and issues confronting an individual Medical Director are discussed.

MHM strives to ensure that new psychiatric staff are well-informed regarding the unique requirements of providing services within a correctional environment. While onsite orientation is provided for new staff, MHM's Medical Directors have developed a comprehensive manual to assist in the orientation of new psychiatric staff to correctional psychiatry. The manual includes the following topics:

- Introduction to Corrections
- Legal Mandates for Correctional Mental Health
- Who is Your Patient/Client?
- Clinical Boundaries and Safe Practices
- Tips to be a Welcomed Guest
- Who is MHM?
- Principles for Psychiatric Services
- Medication Management
- Laboratory Testing
- Treatment Compliance
- How to Work with Inmates Who Do Not Like Your Decisions
- MHM Model Policies & Procedures
- Articles Related to Correctional Psychiatry
- Contract-Specific Policies and Procedures

MHM's Psychiatric Orientation Manual addresses the "challenges" typically confronted by staff new to corrections as well as provides new staff a ready reference for MHM and client-specific policies related to psychiatric practices.

The Mental Health Services Vendor shall provide the following services:

MENTAL HEALTH SUPERVISOR

a) A clinical and administrative supervisor for the therapists who is responsible for coordinating all DDOC on-site mental health clinical operations with DDOC through the facility administrator as well as the facility security staff. The supervisor shall:

- **Supervise, administratively and clinically, all Mental Health Services Vendor staff providing services within the DDOC;**
- **Be held accountable by the Mental Health Services Vendor for meeting the mental health program obligations detailed in this RFP; and**
- **Work closely with the DDOC Mental Health Administrator.**

MHM acknowledges, accepts, and will comply with the above requirements.

In addition to the management positions we establish on site, MHM includes a system of regional management to ensure sufficient support and oversight at the institutional level. For each of our contracts, MHM establishes a Program Manager (referred to as the Mental Health Administrator in the RFP) who has statewide responsibility for the program and is responsible for all aspects of contract management within the established budget. This individual will serve as the administrative and programmatic supervisor for the mental health staff and will serve as the primary point of contact for the DDOC. He or she will implement and follow client agency policies and procedures, and when under a consent decree or Memorandum of Agreement, ensure mental health operations are in accordance with the settlement agreement. To do so, the Program Manager will conduct frequent site visits to prison facilities to review program operations at every level. For the State of Delaware, the Program Manager will work closely with the DDOC Mental Health Administrator and will coordinate with facility security staff as needed.

During start-up, the Program Manager will participate in the initial site visits to the facilities and meet with staff. He or she will also aid in the training and orientation of new staff.

Because of the importance of this position, MHM proposes to present the program manager candidate(s) to the DDOC for review and approval prior to formal hire. Additional regional management will be provided by Robert "Mike" Hooper, PhD. who will serve as Regional Director and provide oversight for both the mental health and substance abuse programs. His resume is included in **Attachment G,** and a brief biography is provided in *Tab 2, Section III, B.1.*

ASSESSMENTS

b) The Vendor shall perform mental health assessments, including evaluations to determine whether an offender is competent to make medical decisions, subsequent to referral by the Medical Services Vendor, the facility warden (or designee), or DDOC Treatment staff at intake or at any time during the offenders incarceration.

MHM acknowledges, accepts, and will comply with the above requirements.

MHM staff have extensive expertise in conducting mental health assessments in correctional settings. We are aware of the unique factors that can influence the assessment process in jails and prisons; the unique mental health needs that offenders have; and the specialized clinical, ethical and forensic issues that must be addressed during mental health assessments. MHM staff complete specialized assessments as clinically indicated.

Indications for mental health assessment may occur when offenders screen positively for mental health needs during the reception process; when offenders with serious mental illness receive disciplinary reports and/or are placed in segregation units; when offenders require crisis interventions; when offenders are being considered for transfer from one level of mental health treatment to another; when requested for pre-parole purposes; and

when referrals from medical, administrative or custody staff raise concerns regarding offenders' capacity to make informed decisions regarding their healthcare.

When questions arise regarding an offender's ability to make medical decisions, specialized assessment of the offender's decision-making capacities is required. MHM supports the DDOC's emphasis on conducting such assessments. While offenders' autonomy and right to refuse treatment and nutrition are essential and constitutionally protected rights, assessment of the capacity to make informed medical decisions is equally crucial to the welfare of offenders who are compromised by psychiatric, cognitive or medical conditions. Decision-making capacities can be compromised by mental health conditions such as severe mental illness, dementia, or developmental disabilities and by medical conditions such as head trauma, severe malnutrition, acute pain, or toxicity. Capacity to make informed medical decisions can also be questioned when there are communication challenges which raise concerns that the offender may not be able to express a choice regarding the proposed medical condition. Perhaps most frequently, assessment of decision-making capacity is needed when offenders engage in hunger strikes.

MHM has developed detailed policies and procedures for monitoring offenders who persistently refuse nutrition, and these procedures include the mental health assessment of the offender's decision-making capacities. When concerns arise that informed consent cannot be given due to impaired capacity, MHM supports the specialized mental health assessment of the offender, regardless of whether the issue is related to psychiatric, nutritional, or medical treatment.

MHM's mental health assessment of an offender's capacity to make informed medical conditions is guided by agency policy and relevant case law. These evaluations are conducted through face-to-face interviews with the offender, consultation with the referring treatment provider, and record reviews. Psychiatric or licensed psychological staff assess the following areas:

- The offender's diagnoses of medical and/or mental illnesses
- The offender's mental status
- The key elements of the proposed treatment
- The offender's functional capacities, including:

  - Ability to understand the information that is being disclosed during the informed consent process
  - Ability to appreciate the relevance of this information for the offender's own circumstances
  - Ability to reason with the information, including the ability to weigh options, risks, benefits, alternatives, and consequences of not receiving the treatment
  - Ability to express a choice with regard to the proposed treatment.

Due to the specialized nature of this mental health assessment, MHM has developed

Clinical Guidelines and a documentation template to support staff in completing the assessment of the offender's capacity to make informed medical decisions. These Guidelines and documentation template are attached as **Attachment H**, and may be revised to meet the needs of DDOC.

Completion of a mental health assessment of the offender's ability to make medical decisions is considered urgent and will be completed no later than one business day following receipt of referral.

Other types of mental health assessments are discussed in relevant sections later in this proposal.

DATA ENTRY: THE DACS SYSTEM

c) The Vendor is responsible for assuring its staff uses DACS for all its intended purposes related to mental health. Initial training on the system will be provided by DDOC staff. Follow up training is the responsibility of the Vendor.

MHM acknowledges, accepts, and will comply with the above requirements.

MHM will ensure that mental health staff utilize the Delaware Automated Clinical System (DACS) as required by the DDOC. Our staff have experience with web-based offender information systems and utilize automated information systems in most contracts where MHM provides correctional mental health care. We understand that DACS is an Oracle-based program used for the initial receiving screening at intake; transfers; mental health care appointment scheduling, including chronic care and specialty clinics; offender health service request (sick call) tracking, triage, and appointments; offender grievances and responses to those grievances; tracking outside consultations; and identification of offenders with chronic medical or mental health conditions.

If awarded the contract, MHM will collaborate with the DDOC to establish a schedule for training all new mental health and substance abuse staff. As the DDOC training is being completed, MHM will identify DACS leaders and trainers from among MHM staff. These individuals will function as "local experts" who will be responsible for follow-up training of MHM staff throughout the life of the contract. Utilization of DACS will be assured through ongoing training, supervision, and CQI monitoring. We understand the need for timely data entry into DACS, not only for continuity and consistency in care, but also for purposes of generating required utilization management, risk management, and CQI reports.

CASE MANAGEMENT

d) The Vendor shall provide Case Management of offenders with psychiatric histories or symptoms, including:

- **Serious mental illness;**
- **Adjustment difficulties;**

- **Decompensation;**
- **Aggressive behavior and/or victimization;**
- **Suicidal/homicidal ideation;**
- **Dementia; and**
- **Other significant cognitive/emotional impairment.**

MHM acknowledges, accepts, and will comply with the above requirements.

MHM clinical staff will provide Case Management services to all offenders on the mental health caseload. We strongly support the DDOC's goal of ensuring continuity of care and maximizing treatment for each offender who is receiving mental health services. MHM understands case management services to include the development of individualized treatment plans; coordination and monitoring of treatment under this plan to ensure that treatment needs are being met and that progress towards treatment goals is being regularly assessed; integration of findings and recommendations from any specialty consults into the offender's ongoing treatment as clinically indicated; communication sufficient to ensure continuity of care when offenders are transferred between institutions or levels of care; and re-entry planning to link offenders with mental health resources in the community.

MHM will follow all DDOC policies and NCCHC standards in providing Case Management services to offenders receiving mental health treatment. Treatment and discharge planning will be carried out according to DDOC protocols, including the utilization of DACS. Case Management services address but are not limited to the following areas for caseload offenders:

- Amelioration of symptoms of serious mental illness
- Amelioration of adjustment difficulties, including those that require supportive and skills-building treatment
- Support for psychiatric and behavioral stability, including provision of mental health interventions that guard against decompensation
- Reduction of aggressive behavior and homicidal ideation associated with mental illness
- Treatment and management of exposure to trauma or victimization
- Reduction of suicidal and self-injurious ideation and behavior
- In collaboration with medical staff, management of psychiatric and behavioral components of dementia
- Mental health support and planning for offenders with developmental or intellectual disabilities (such as significant cognitive or emotional impairment)

MHM has developed extensive policies, procedures, treatment guidelines, individual and group programming, and specialized protocols that can be utilized to guide Case Management decisions. MHM's clinical infrastructure is unparalleled in the industry and provides a comprehensive menu of treatment options that can be tailored for individual treatment planning and the needs of the DDOC. Comprehensive staff training in individualized treatment planning (and the management of mental health

services under that plan) is available in MHM's Clinical Operations Resource Manuals. This training has been extensively field tested and has resulted in improved Case Management coordination in the systems where it has been utilized. The content of our mental health programming is discussed below, and our extensive staff training program is described in *Tab 4, Section X,C.3.*

COLLABORATION

e) The Vendor staff shall be available to all offenders and DDOC staff. The Vendor staff shall participate on various review committees and conduct mental health-related training for the DDOC staff and other health services Vendors at the discretion of the OHS Director.

MHM acknowledges, accepts, and will comply with the above requirements.

MHM staff will be available to all offenders and DDOC staff, and will participate in the monthly healthcare operational meetings and interdisciplinary treatment team meetings as well as various review committees, as required. We want to establish frequent, on-going, and robust levels of communication with all stakeholders and we promise the highest level of responsiveness. We will publish instructions and contact information for contacting MHM personnel and provide this information to all facilities and stakeholders.

Collaboration with DDOC Staff

It is likely the Department currently holds regularly scheduled meetings for review of the mental health program. If not, MHM proposes to establish these meetings and invite stakeholders from the DDOC. In addition to daily dialogue among stakeholders, these meetings provide an opportunity for stakeholders to review operational data jointly, discuss action plans, and revise operational procedures and goals as needed. We participate or lead such meetings in all of our contracts and these meetings can occur at varying frequency depending on the nature of our contract or client preference.

Typically, we participate in a monthly operations meeting during which program statistical reports are presented, staffing issues are discussed, and short and long-term program issues are reviewed. At facilities with significant mental health programs and larger numbers of mental health personnel, we also propose to hold regularly occurring operational meetings for a similar purpose if such meetings are not already in place.

As a matter of routine, our Program Manager and other support staff make it a point to meet with the administration (i.e. Warden/Assistant Warden) of each institution whenever on-site.

Examples of our integrated approach include the following:

- Facilitate bi-weekly meetings with regional leadership to discuss issues and developments in the provision of health care

- Offer training on topics related to mental health to health services and security staff.
- Include Wardens and health services staff in discussions about staffing and recruitment issues.
- Maintain frequent contact with facility administrators to obtain feedback on the quality of services provided by MHM staff and the overall operations of the mental health program.
- Openly acknowledge areas of concern and keep institutional leadership (i.e., Warden and/or Assistant Warden) apprised of corrective actions.

We encourage weekly meetings between the mental health leadership and medical services staff at each institution with significant mental health services. These leadership meetings, which often include the Warden or Assistant Warden, are instrumental in the ongoing improvement of mental health services. We also feel it is important to involve facility leadership and medical services staff in the recruitment and orientation process for new personnel.

Collaboration with the Medical Vendor

MHM feels it is particularly important for psychiatric staff to liaison effectively with medical personnel and we will work to establish relationships with the medical personnel at each facility. We will make our psychiatry staff available to participate as appropriate in various medical meetings, treatment team meetings, pharmacy and therapeutics committee meetings, and other meetings as needed. We recognize there is often a need for psychiatry staff to provide consultation services for primary care physicians and we will ensure our staff communicate and collaborate effectively with medical personnel for this purpose.

We develop collaborative relationships with medical staff to ensure that information about a specific offender is shared when there are co-occurring medical and mental health issues. This collaboration includes joint treatment planning and is essential when an offender is experiencing end-of-life, pregnancy or substance abuse/withdrawal issues. This process ensures that psychiatric and non-medical interventions are considered and discussed to achieve the optimal treatment approach for individual offenders. Treatment team meetings and day-to-day contact with medical staff will be the main methods for sharing information among staff. When psychiatric presence at treatment team meetings is not possible due to scheduling issues, the psychiatric staff will be available for consultation and will review and approve the treatment plans.

In our current contracts, we have demonstrated our ability to develop collaborative relationships with other departments to ensure that offenders receive the comprehensive services required. During the implementation phase of the contract, we will collaborate with the DDOC's medical provider to ensure that we have a clear understanding of how best to integrate our services into the total continuum of offender care.

Training: Identifying Mental Illness

MHM makes its training resources available for our client agencies beyond the personnel provided by MHM. We offer training modules for security staff regarding the basic identification of offenders who may require immediate mental health attention. All training is provided in a manner consistent with all applicable NCCHC standards, and is available for implementation at the OHS Director's discretion.

Our Correctional Officer training includes in-person orientations and written materials with a focus on identifying offenders requiring immediate mental health attention consistent with the NCCHC standards. The MHM training curriculum for Correctional Officers includes:

- Recognizing the signs and symptoms of mental illness
- Recognizing the signs and symptoms of change of mental status
- Psychotropic medication benefits, potential side effects, and the importance of medication compliance
- Recognizing suicidal behavior and procedures/protocols for suicide prevention
- Management techniques for offenders with serious mental illness and/or limited cognitive functioning
- Recognizing the signs and symptoms of mental illness, psychological trauma, and acute and chronic serious functional impairments
- Triaging and obtaining urgent and emergent mental health services

MHM works closely with the Warden to schedule officer trainings that meet the scheduling needs of the facility. MHM has found that conducting training with security staff in mental health issues, particularly when there is change in practice or a new program is being implemented, is essential to ensuring a successful mental health program. These trainings are not only important for sharing information but also for developing rapport among security and mental health staff.

For further information regarding collaboration, see *Tab 4, Section X, C.16.*

SUICIDE PREVENTION

f. The Vendor will coordinate with the DDOC BCHS training in and actual compliance with the DDOC's suicide prevention procedures to be followed by all health care staff. The Vendor is responsible for suicide prevention as outlined in the DDOC Policy G-05, Suicide Prevention, Policies and Procedures.

MHM acknowledges, accepts, and will comply with the above requirements.

We fully appreciate the suicide risks that accompany the offender population. Our staff are focused on identifying and reducing suicide risk. We recognize that suicide prevention is a shared responsibility of all team members within a correctional department. Therefore, we work jointly with our client agencies to ensure suicide prevention awareness is maintained at a high level and that all staff including security, medical, and administrative personnel receive sufficient and ongoing training on suicide prevention. At correctional facilities where the medical provider conducts the reception/intake evaluation, we offer training to medical staff to assess and identify offenders at risk for suicide. Our Clinical Operations team has extensive experience developing and providing suicide prevention training in correctional settings and will coordinate with the DDOC BCHS to ensure training is in accordance with DDOC procedures.

As determined by the DDOC, we will support a multi-faceted suicide prevention strategy for our mental health services and staff that engages a team approach to avert suicide attempts and effectively address completed suicides. The program will encompass a comprehensive staff training module, which is an integral part of the basic mental health and job-specific training programs we offer. In this program, we will integrate key roles and functions with DDOC staff and other health care providers. MHM will design this module to be consistent with the DDOC's established curriculum for its own staff training in suicide and self-injury prevention.

Our suicide prevention strategy includes assessing, screening, and monitoring offenders at risk for suicide; suicide watch plans and appropriate treatment services; forums to facilitate effective communication among staff; and critical incident debriefings after a suicide or serious suicide attempt.

Formalized suicide risk assessments will be completed within 24 hours of the initiation of suicide watch. These assessments will include, at a minimum:

- Description of antecedent events and precipitating factors
- Suicidal indicators
- Mental status examination
- Previous psychiatric and suicidal risk history
- Level of lethality
- Current medication and diagnosis
- Recommendations and treatment plan

MHM will engage in daily interactions (not just observations) and assessments while the inmate is on watch, and our staff will document all of these contacts. Our staff are trained to document the rationale for all decisions regarding suicide precautions in progress notes. In addition, we understand that offenders cannot be downgraded or discharged from suicide precautions until a thorough review of the offender's health record and consultation with correctional staff have taken place. MHM will follow DDOC policy and protocol with respect to introducing step-down levels of observation following release/downgrading from suicide precaution.

Through our suicide prevention programs we train staff to identify and refer offenders who are potentially at risk for suicidal and self-injurious behavior, intervene and monitor offenders identified as potentially suicidal, and provide mental health evaluations and treatment. Our current program also has a component that addresses incident debriefing for serious suicide attempts or completions as well as quality improvement monitoring of the suicide prevention program, including a mental health post-mortem review of offender suicides. MHM's Clinical Operations manage an ongoing, company-wide study of completed suicides and suicide attempts that required significant medical interventions. The results of this study will be updated and integrated into staff training on an ongoing basis.

It is understood that correctional officers provide watch when an inmate is placed on Level I observation per DDOC Policy 11-G-05.

MENTAL HEALTH PROGRAMMING

g) Mental Health Programming - Upon request or referral, each offender shall receive an initial assessment and orientation to the services available including the following:

i. **Individual assignment to Mental Health Services Vendor staff - Each offender identified as in need of mental health treatment shall be assigned to a primary therapist (at the facility in which the offender resides) who shall provide individualized,**
ii. **One-on-one treatment and discharge planning, and**
iii. **Group treatment activities in general population or on a Special Needs Unit and shall also be included in services provided to the extent called for in the program statements developed by the DDOC and determined clinically appropriate by the Vendor's clinicians, and**
iv. **Group treatment and other mental health programming shall be provided to jail and prison offenders in segregation and in general population.**

MHM acknowledges, accepts, and will comply with the above requirements.

Upon intake, request, or referral, each offender will receive an initial assessment and orientation to the services available, including those identified above.

Initial Assessment & Orientation

Identification of an offender's mental health needs begins during the reception process and is maintained throughout the offender's incarceration. Assessment of an offender's mental health needs is typically the result of mental health staff assessment of the offender at reception or in response to a crisis, security or medical staff referral, or an offender's request for mental health assistance. This initial assessment is based on the offender's presentation and self-report. The use of a standardized assessment instrument prompts staff in ensuring that all clinically relevant information is considered. During the

initial assessment, the offender is provided written and verbal information about the mental health services that are available and how to access these services.

The offender is referred to a psychiatrist if clinically indicated. Prior records of psychiatric treatment are requested when these could be helpful in planning for the offender's on-going care. The assessments of the mental health and psychiatric staff provide the foundation for the offender's treatment plan.

Initial mental health assessments are scheduled based on the current presentation of the offender:

- Emergency referrals for offenders in need of immediate psychiatric attention or presenting risk for self-harm are seen face-to-face as soon as possible. In all cases, emergency evaluations are completed within four hours of referral. If there are no psychiatric staff on-site, mental health staff who are present will conduct a preliminary assessment in consultation with the on-call psychiatrist. The offender is maintained under constant observation until the assessment has been completed.
- Offenders who screen positive for serious mental illness and/or are on psychotropic medication at reception are seen within twenty-four to seventy-two hours of initial mental health screening. Offenders who were prescribed psychotropic medication for a serious mental illness prior to admission to the correctional system may have medication continued until the mental health assessment through bridge orders based on verification of the medication orders and/or consultation with the on-site or on-call psychiatric staff.
- Offenders who request routine mental health services or who are identified at reception as having mental health issues in the past receive a mental health assessment within seven working days of the referral.

Follow-up

Offenders identified by the initial mental health assessment as requiring mental health services are placed on the mental health caseload and assigned to a primary mental health staff member for routine follow-up. Offenders on the mental health caseload are seen by the assigned mental health staff member as clinically indicated but no less than every 30 days. This follow-up is in addition to the follow-up provided by psychiatric staff.

The monthly individual offender follow-up by the assigned mental health staff member is often not structured to be psychotherapy. The focus is to assess the offender's current functioning and to determine if the offender is experiencing any problems with maintaining adequate functioning. Individual psychotherapy is often a "luxury" in the correctional environment due to numerous service delivery demands and staffing allocations. MHM staff are expected to engage offenders in group treatment unless clinically contraindicated. Extensive individual treatment is typically restricted to the follow-up of crisis interventions to include the mental health services required by PREA mandates and to provide specialized behavioral interventions, when indicated.

Group Modules

MHM has developed a wide range of psychoeducational group modules (see **Attachment I**). These modules assist on-site mental health staff in providing quality group treatment for offenders at different levels of functioning. All of MHM's psychoeducational groups are structured with learning objectives, group leader outlines, offender handouts, and pre/post tests to assess clinical outcomes. On-site staff are encouraged to ensure that the recommended content is covered while tailoring the presentation to their personal styles. A list of MHM's current group curriculum follows.

Groups for Average/High Functioning Offenders

- Psychotropic Medication Education Group
- Sleep Hygiene Group
- Cognitive Behavioral Therapy Group
- Cage Your Rage
- Depression Group
- Trauma Group
- Anger Management (High Functioning)
- Anger Management (Average Functioning)
- Dealing with Feelings (High Functioning)
- Grief Support Group
- Coping with Incarceration
- Responsible Parenting
- Coping and Hoping – Self-Injury
- Life After Release
- Adjustment Skills Group
- Anxiety Group

Group/Activities for Challenged Offenders

- Accepting Mental Illness
- Handle Anger Better
- Personal Hygiene
- Planning for a Better Life
- Self-Esteem for Challenged Offenders
- Exploring the United States
- Activities (7)

Our group curriculum provides a consistent approach to the mental health issues typically addressed within corrections. As evidence of the quality of MHM's programming, the

Missouri Department of Corrections has adopted the MHM Anger Management group for implementation. Completion of the programming meets the requirement for anger management treatment for parole consideration.

While the response to the MHM group curriculum from our clients and offenders has been positive, we have instituted company-wide assessments of treatment outcomes in order to measure the clinical effectiveness of the groups in fostering offender change. To date, we have collected several hundred pre- and post-group outcome tests. This information is critical to ensure the effectiveness of the group process and will be made available to MHM's clients as analyses are completed.

Encouraging Offender Participation

A significant challenge in developing programming for mental health units is designing programs in which the offenders choose to participate. Many offenders on treatment units would prefer not to participate and to be left alone. MHM implements level systems and incentive programs in which an offender is "rewarded" for participation in programming. As previously indicated, MHM has also developed group curriculum that is consistent with the functioning and interests of challenged offenders.

Tracking individual offender participation in structured therapeutic programming is essential for treatment plan monitoring. Attendance at groups is confirmed by the offender's signature on an attendance roster. These rosters are analyzed to provide summary data on the provision of structured programming as well as individual offender participation in the programming.

Providing Care in Segregation Units

MHM is very aware of the challenges in providing mental health services for offenders in segregation units. Our process for providing mental health consultation to the disciplinary process for offenders with severe mental illness is described in ***Section o***, below. Our program for providing mental health services to segregation units is consistent with NCCHC and ACA standards. MHM staff address the elevated stress associated with restrictive housing units and the reduced access offenders housed in these areas have to general population mental health services by completing no less than weekly cell-to-cell rounds for offenders who do not have a mental health condition. In accordance with DDOC policy 11-E-09, MHM staff will conduct rounds for offenders with mental health conditions three times a week.

During these rounds, a mental health staff member approaches each cell and asks how the offender is doing. We require our staff to have both verbal and visual contact with each offender. The rounds are not a substitute for treatment but are conducted to enable offenders to request assistance and to identify those offenders who may be experiencing distress but who have not asked for assistance. Documentation of rounds is provided in accordance with NCCHC and Departmental standards. When follow-up is required, the offender is scheduled for a timely mental health contact.

Further, the mental health rounds provide mental health staff the opportunity to enhance rapport with the correctional officers of the segregation units and to provide consultation regarding specific offenders. The correctional officers are provided a roster of offenders receiving on-going mental health services each week to alert them to offenders with significant mental health issues.

In other contracts, mental health staff review segregation unit rosters daily in order to identify when an offender receiving mental health services has been placed in a restrictive unit. MHM understands that in the DDOC, mental health staff will be notified by medical staff through DACS when offenders with serious mental illness are placed in segregation. According to DDOC policy, offenders who currently have serious mental illness or who have received treatment for serious mental illness within the prior five years will be referred under this process. These offenders are assessed by their assigned mental health staff member within 24 hours of notification of the segregation placement. This assessment will be completed according to DDOC policy and procedure. Offenders with mental health needs receive subsequent follow-up as clinically indicated. This follow-up is in addition to the contact with mental health staff through the mental health rounds mentioned previously.

Mental health staff complete documented mental health assessments of offenders housed in segregation units for more than 30 days and every 90 days thereafter. These assessments are consistent with ACA standards. When an offender is demonstrating significant adjustment issues to segregated placement due to serious mental illness, potential options to address the mental health issues are considered. In some of our existing contracts, mental health staff routinely participate in segregation placement reviews to ensure safety and stability.

Taking a Chance on Change Program

MHM developed the Taking a Chance on Change (TCC) program in response to meeting the challenges of providing adequate programming for offenders who are not able to participate in out-of-cell group programming. The TCC program is a structured in-cell treatment program designed to provide offenders housed in long-term restrictive units with the opportunity to participate in psychoeducation. When it is possible to conduct groups with segregated offenders, the TCC program has proved useful in preparing the offenders for participation in the group process.

The TCC program is divided into eight units. Each unit includes four to eight modules, each module containing a handout and worksheet. Offenders are given a week to review each module's handout and complete the related worksheet. At the conclusion of a specific unit, a module reviewing the concepts discussed and an in-cell/open-book assessment is conducted to reinforce the offender's understanding of the unit's concepts. The program has recently been enhanced through translation of the program to Spanish.

The topics of the eight units of the TCC program are:

1. Preparing for Change
2. Self-Awareness/Goal Setting
3. Identifying and Changing Mistaken Beliefs
4. Effective Problem-Solving
5. Effective Communication
6. Anger Management
7. Stress Management
8. Relapse Prevention

Completion of the entire TCC program requires nine to twelve months; however, offenders may participate in individual units without completing the entire program. Priority for program participation is given to offenders referred by security supervisors and correctional officers. Although the reading level of the TCC program has been designed to be comprehended by individuals with limited academic skills, an offender needs basic language skills to participate.

The TCC program is provided to offenders of long-term restrictive housing units during mental health cell-to-cell rounds. Each week, the MHM staff member conducting the rounds distributes a handout and worksheet for the next module and collects the worksheet completed by the offender for the prior week's handout. Offenders have the opportunity to briefly discuss the module's content with the mental health staff during the rounds.

Implementation of the TCC program has been applauded by the offenders, segregation unit correctional officers, and wardens of the Maryland prisons. Although offenders were informed when beginning the TCC program that participation would not affect the length of time they would be housed in the segregation units, wardens have begun to reduce segregation time for offenders who successfully complete units of the program. The TCC program has been successfully implemented in MHM's Massachusetts, Missouri, and Tennessee contracts as well. During the last year, MHM has begun formal assessment of the TCC, using pre- and post-tests measuring criminal thinking styles. Like our pre- and post-group data, the results of our TCC effectiveness data will be made available to MHM's clients when sufficient data have been collected and analyses are completed.

MHM proposes to pilot this program at Sussex Correctional Institution, working with Warden Mike Deloy. If it proves successful (as it has in other states), MHM recommends implementing it at the DDOC's additional Level V facilities (Howard R.Young Correctional Institution, James T. Vaughn Correctional Center, and Baylor Women Correctional Institution).

Discharge Planning

Discharge planning begins for offenders placed on the mental health caseload when developing the offender's initial multidisciplinary treatment plan. The scope of the discharge planning is determined by the offender's potential release date and the level of support the offender may need to be successful in the community transition. At a minimum, offenders are provided a list of community mental health and support agency contacts. For offenders prescribed psychotropic medication, attempts are made to schedule an appointment for the offender with the community mental health agency where the offender will be living. With the offender's authorization, information about the mental health services provided for the offender while incarcerated is shared with the community agency. When released, the offender is provided an interim supply of psychotropic medication to facilitate continuity of care until seen by the community agency.

For offenders significantly compromised by mental illness or limited cognitive functioning, mental health staff will cooperate with DDOC case management staff in attempting to establish adequate housing and support for the offender at release. If the offender meets civil commitment criteria, mental health staff will initiate the process to assist the offender in accessing inpatient psychiatric treatment within the community.

MHM supports effective pre-release planning because we understand the relationship between mental health treatment in the community and offender recidivism. We actively pursue the development of collaborative community agency linkages. We also encourage community staff involvement in discharge treatment planning. MHM has extensive experience participating in re-entry initiatives in challenging environments including the Pennsylvania Department of Corrections, Philadelphia Prison System, the Salt Lake County Jail, and the Kansas City Community Release Center (Missouri Department of Corrections), among others.

MHM is also prepared to work with the DDOC in maintaining and expanding diversion programs for pre-trial offenders with mental illness who might be better served by mental health treatment and support rather than incarceration. MHM has successfully been engaged in diversion programs, including involvement with Mental Health Courts, in our Salt Lake County and Philadelphia jail contracts.

RECEIVING SCREENING

h) Receiving Screening – Mental health screening at intake will be performed by Medical Services Vendor's staff during the comprehensive intake screening and recorded in DACS. Offenders demonstrating the following will be referred for additional evaluation and testing with a notification to Mental Health Services Vendor's staff via DACS:

- **Impaired cognitive functioning,**
- **Offenders identified as having "special needs" related to mental disorders, and**

- **Significant psychological distress or positive signs for potential of mental health disease/diagnosis.**

In the event of a positive response to a question on the mental health portion of the receiving screening, qualified mental health professionals, including psychiatrists, psychiatric nurse practitioners, psychologists, psychiatric nurses, mental health clinicians or psychiatric social workers will perform further mental health evaluation within 24 hours. The mental health evaluation will be filed in the Offender Medical Record. On-call staff must be available 24/7 for those identified during initial screening to require immediate mental health evaluation and assessment.

MHM acknowledges, accepts, and will comply with the above requirements.

MHM understands that the initial mental health screening conducted at intake for newly received offenders will be completed by the medical vendor's staff, and that this screening will be entered into DACS. NCCHC requires that, if the initial mental health screening is conducted by medical staff, such staff must be adequately trained in mental health screening. MHM offers such training, as we routinely provide it to healthcare staff who conduct initial screenings in our other contracts. Due to the turnover of nursing staff that is common in correctional settings, we anticipate the need to provide such training periodically, but no less than once a year.

We understand that we will receive notification of the need for additional mental health assessment through DACS and that mental health needs may include the following:

- Special needs that require mental health treatment due to the presence of mental disorders
- Significant psychological or emotional distress.
- Impaired cognitive functioning

In addition, offenders whose presentation during the screening suggests the possibility that a mental illness may be present are referred for an initial mental health assessment.

MHM understands that over 80% of all newly received offenders screen positive for mental health needs and that all initial mental health assessments must be completed within 24 hours of the initial screening. Offenders who are judged to be at risk for suicidal behavior during the initial screening are placed on Constant Observation status in a safe cell while an order for placement on psychiatric observation status is obtained, and a full mental health assessment is completed according to policy. MHM will retain sufficient staffing to meet the DDOC's requirement for 24/7 on-call coverage for offenders who, on initial screening, are deemed in need of immediate mental health assessment.

Initial mental health assessments will be conducted in accordance with DDOC and NCCHC standards. Assessment of offender functioning and symptoms is conducted in the context of multidisciplinary collaboration and the utilization of multiple data sources. MHM has

developed in-depth staff training regarding the liabilities of relying exclusively upon offender self-report. We strive to meet or exceed community standards by obtaining medication verification and prior mental health records for offenders who are being screened at reception or evaluated for placement on the mental health caseload.

Our mental health assessments meet all NCCHC and ACA standards in breadth and content. Among other components, our mental health assessments include mental status examinations; pertinent history (e.g., psychiatric treatment, education, substance use/abuse and treatment, head trauma/seizure, exposure to traumatic events); intellectual functioning; adjustment to incarceration; coping styles; strengths and vulnerabilities; and diagnostic impressions.

Additionally, for offenders who are referred for mental health assessment due to concerns of suicidal risk, the initial mental health assessment will include specific inquiry into the following areas:

- The offender's statements or behavior that led to the referral
- The offender's history of suicidal and self-injurious behaviors, including:
  - When these behaviors occurred
  - How frequently the behaviors have occurred
  - The circumstances under which they occurred, including the triggers for the behavior and the consequences that may have reinforced the behavior
  - The method(s) the offender used to engage in self-injurious/suicidal behavior
  - The treatments that were required to restore safety following these behaviors
- The offender's current suicidal risk, including but not limited to:
  - The nature of any current suicidal ideation (active versus passive; fleeting versus persistent)
  - The presence of any suicidal plan, its feasibility and potential lethality
  - The presence of other warning signs such as intense shame, anger, agitation, panic, anxiety, depression or sudden change in mental status
  - The degree to which the offender is socially isolated, facing social rejection or alienation
- Protective factors, including
  - Future orientation
  - Coping skills
  - Social connectedness (e.g., family support)
  - Engagement in treatment and motivation for change

Absent a psychiatric emergency, initial mental health assessments are typically conducted by master's level licensed mental health staff. If referred, the offender is then seen by psychiatric staff for further evaluation. Particularly at reception sites and when offenders are new to the caseload, it is common for different mental health professionals to assess and diagnose the offender with somewhat different impressions. MHM staff anticipate

the emergence of divergent opinions in these cases, and ensure that multidisciplinary collaboration and peer consultation take place to resolve discrepant clinical opinions.

TREATMENT PLANS

i) Treatment Plans - Each offender receiving mental health treatment, who remains in the DDOC for more than 72 hours, will be offered the opportunity to collaborate with the Interdisciplinary Treatment Team (ITT), including representatives from the Medical Services Vendor, the Mental Health Services Vendor, DDOC Security for the facility, DDOC treatment staff, and other ancillary staff, in the development of an individualized treatment plan, and to agree to this plan in writing. Basic plans will be developed by the ITT even when offenders decline to participate.

MHM acknowledges, accepts, and will comply with the above requirements.

We fully support the DDOC's policies and standards for completion of individualized treatment plans for each offender who requires mental health treatment. Multidisciplinary treatment planning is essential for offenders with special needs and mental health conditions. MHM strives to offer a coordinated, integrated approach to offender treatment. This coordination is facilitated by the multidisciplinary treatment planning process which ensures that psychiatric, medical, and non-medical interventions (as well as security issues) are considered and discussed to achieve the optimal treatment approach for individual offenders. When psychiatric presence at treatment team meetings is not possible due to scheduling issues, psychiatric staff will be available for consultation and will review and approve the treatment plans. MHM is eager to explore the possible role of telepsychiatry (see *Section u, below*) in increasing psychiatric staff participation in treatment planning meetings.

MHM's treatment planning process meets all NCCHC and ACA standards. We have extensive clinical infrastructure to support individualized treatment planning. Most recently, MHM has been developing treatment planning processes that support recovery principles as outlined in the Presidential New Freedom Commission report. To our knowledge, *MHM is the first provider of mental health services to take the recovery model inside prison walls*.

As part of the formulation of individualized treatment plans, MHM staff utilize the Risk-Need-Responsivity model to conduct assessments of offender's treatment needs. Under this model, risk factors for dangerous behaviors are identified. Offender's individualized needs for treatment are also identified through collaboration with the offender, review of prior treatment responses, and an understanding of the offender's personal goals.

MHM is careful to craft treatment interventions that meet individual offender's specific capacities for responding to treatment ("Responsivity"). Many offenders struggle with attention and concentration due to severe mental illness. Others struggle with written homework or other treatment materials due to developmental disabilities or educational limitations. As discussed earlier, MHM has created structured psychoeducational and

treatment materials that address treatment needs for low functioning/highly challenged, moderately functioning, and high functioning offenders.

Functional and diagnostic assessments are completed before individualized treatment plans are formulated. MHM has developed an extensive array of treatment planning tools including templates, staff training, and quality improvement tools. We ensure that the major challenges and strengths identified in mental health assessments are addressed in individualized, comprehensive treatment plans.

Crisis Treatment Planning

MHM has specific training, guidelines, and templates focused on crisis treatment planning, an area that is frequently under-supported but essential in correctional mental health. We are well aware that some offenders are placed on watch with the primary treatment being observation and time. Much more active crisis treatment planning is needed if mental health watches are to be utilized as part of an array of treatment interventions and not simply as safe custody. Crisis treatment planning attempts to address the core mental health issues that lead to the crisis; and experience confirms that when these issues are appropriately addressed, the need for prolonged mental health or suicide watches decreases significantly.

Ensuring Effective Treatment Planning

MHM's staff training helps ensure that the offender's individual treatment plan is a "living document" which reflects and guides the actual treatment that is being provided. Assessment does not end with the formation of an initial treatment plan. MHM is committed to accountability and transparency in the provision of mental health services. We assess offender's progress towards identified treatment objectives to ensure that our interventions are effective. This is an ongoing process. It is anticipated that offenders will respond to treatment and that their treatment needs will change. Treatment plans are reviewed on a frequency dictated by clinical need and policy, and these treatment reviews occur in a multidisciplinary context.

Further, offenders' responses to treatment interventions are documented with each progress note. Staff are trained to develop progress notes that tie directly to the treatment plan. Documentation of individual and group encounters focuses in part on the offender's response to interventions and progress towards treatment objectives that are specified in the treatment plan. This process helps prevent "mission drift." By requiring progress notes to be truly "progress" notes, and not just encounter or status notes, MHM ensures that therapeutic encounters align with the treatment interventions set forth in the treatment plan. The treatment plan then becomes embodied in the progress note and guides treatment in a meaningful manner.

PSYCHIATRIC NURSING SERVICES

j) Psychiatric Nursing Services - The Medical Services Vendor's nursing staff shall provide support in delivering mental health medications to the offenders that require it. All psychiatric assessments will receive nursing support and monitoring based on training and orientation provided by the Mental Health Services Vendor.

MHM acknowledges, accepts, and will comply with the above requirements. As the largest private provider of correctional mental health services, MHM has extensive experience working collaboratively with psychiatric nursing from medical staff. We routinely collaborate with other vendors' nursing staff since they administer the psychotropic medications prescribed by our psychiatric staff. We anticipate relying extensively on medical nursing staff in general population and segregation units.

Medication administration and compliance are major issues within corrections. It is essential that there is a process to ensure that psychiatric staff are informed of offender psychotropic medication non-compliance. Since offender self-reports of medication compliance are not reliable, regular review of the medication administration records is necessary. MHM understands that the DDOC uses three or more consecutive missed doses or three doses missed on consecutive days as the thresholds for reporting medication noncompliance, and that medical nurses will notify MHM's psychiatric staff in writing when offenders cross these thresholds.

MHM psychiatric staff are expected to provide timely follow-up for offenders exhibiting patterns of medication noncompliance. Although offenders have the right to refuse treatment, an offender who refuses medication will be maintained on the mental health caseload if the treatment team considers the offender to be at risk for acute psychosis or significant psychiatric decompensation without medication.

Training & Orientation

To assist nursing staff in supporting psychiatric care and monitoring offenders for medication compliance and response to medications, MHM will provide nursing staff with training and orientation in psychiatric diagnoses, expected responses to psychotropic medications, important side effects, mental status examinations, signs and symptoms of psychiatric decompensation and suicidality, and signs of improvement. MHM has also developed extensive training appropriate for medical staff in de-escalation, the use of least restrictive alternatives, the use of therapeutic restraints, monitoring offenders for behavioral and physiological signs of de-escalation, managing behavioral crises, and urgent care collaboration during such crises.

Like all of MHM's staff training modules (**Attachment F**), each of MHM's training sessions includes a trainer outline, trainee handout, PowerPoint presentation, post-test, evaluation, and trainee post-test key. If awarded the contract, MHM will collaborate closely with the BHCS and the medical vendor to begin scheduling these trainings and

ensuring that the curricula meet DDOC's and the medical vendor's needs. MHM's unparalleled staff training program is discussed in ***Tab 4, Section X, C.3.***

ITT MEETINGS & PARTICIPATION

k) The Mental Health Services Vendor's staff shall participate in the ITT meetings with medical, security, treatment, and other DDOC personnel. The Mental Health Services Vendor shall ensure their staff participate in other areas and activities that pertain to institutional programs and treatment as assigned or selected by the facility warden (or designee) and the BCHS.

MHM acknowledges, accepts, and will comply with the above requirements.

Our staff will participate in the ITT meetings and other areas and activities that pertain to institutional programs and treatment as assigned or selected by the facility warden and the BCHS. For further information regarding collaboration and participation, see *Section e, Collaboration,* above.

Multidisciplinary Treatment Planning

MHM psychiatrists are active members of multidisciplinary treatment teams. They participate in treatment team meetings, provide input into the treatment planning process via documentation and verbal consultation, and utilize routine progress notes to indicate progress toward treatment goals. Psychiatrists regularly participate in treatment team meetings focused on offenders whom they are actively treating with medications. There are times when psychiatrists are asked by the larger treatment team to consult on cases with which they are not actively involved. They participate in these meetings as their schedules permit and provide consultation.

WITHDRAWAL

l) Offenders undergoing withdrawal from habit forming substances shall be monitored according to the clinical protocols of the Medical Services Vendor. DDOC policies and NCCHC standards.

We understand that the medical vendor is responsible for managing those offenders who have been diagnosed as having the signs and symptoms of withdrawal. MHM staff will work with the medical vendor on any of the cases referred to mental health, and for those offenders committed to the department, mental health will perform a screening using the UNCOPE assessment tool.

Referrals will be made for those offenders who are deemed as appropriate candidates for the substance abuse treatment program.

SEX OFFENDER TREATMENT

m) The Vendor shall propose a comprehensive sex offender treatment program at all facilities to include at a minimum, assessment, treatment, and discharge planning as required by DDOC. Sex offender treatment services shall be provided at the direction of the DDOC BCHS and as directed by the courts. See 11 Del. C. §§ 4120 and 4121 for an explanation of sex offender registration and community notification requirements pursuant to Delaware law.

MHM acknowledges, accepts, and will comply with the above requirements and those outlined in the DDOC's responses to bidders' questions. We have currently included two positions for the provision of sex offender treatment services in our pricing. However, it is our understanding that this program has been historically unfunded, which we may discuss further in negotiations.

We believe that sex offender treatment services are best provided in group settings and within the context of a residential therapeutic community. We understand that the DDOC currently incarcerates approximately 450 registered sex offenders. Sex offender treatment services are best provided in weekly group meetings for at least 12 to 18 months. Given the populations across facilities and the staffing matrix, MHM proposes that comprehensive sex offender treatment services be offered at the four Bureau of Prison facilities (BWCI, HRYCI, JTVCC, and SCI), or in a therapeutic community environment at a location designated by the DDOC. Brief psychoeducational services may be indicated at the other facilities, but the average length of incarceration at those facilities prohibits the provision of comprehensive and effective services.

In order to ensure the quality, integrity, and accessibility of sex offender treatment services, MHM proposes two Sex Offender Treatment Coordinators. These individuals will oversee the assessment of sex offenders and the provision of sex offender treatment services across all facilities with one responsible for overseeing the Level IV facilities and the other overseeing Level V facilities. The Sex Offender Treatment Coordinator will also provide supervision to treatment providers and act as liaison with the DDOC's Central Victim Services Unit to support proper sex offender registration and victim notification prior to release to the community.

As discussed under treatment planning, MHM relies on the risk-need-responsivity model of treatment delivery. Utilization of this model is applied not only to traditional mental health services but also to sex offender treatment. This model involves the identification of risk factors, the needs that those risk factors highlight in terms of treatment targets, and the provision of treatment in modalities that are responsive to an offender's individual style of learning and behavioral changes. Our model follows the DDOC's requirement that sex offender treatment be assessment driven.

As such, the process of sex offender treatment begins with an assessment of risk factors as targets for treatment. While the sex offender research has clearly delineated static risk factors (demographic and historical factors that cannot be changed) as the best indicators

of recidivism risk, these factors do not inform treatment. Instead, dynamic risk factors (thinking and coping practices that may be amenable to change) need to be identified in order to provide a foundation for treatment targets. We will utilize the assessment tools required by the DDOC and utilize dynamic risk assessment to determine those risk-need factors which should be targeted for each offender. Dynamic risk-need assessment includes the assessment of the offender across four domains:

1. Sexual interest
2. Sexual attitudes
3. Socio-affective functioning
4. Self-management

Each offender is assessed and rated according to these domains at the initiation of treatment. The offender is then enrolled in groups targeted to address these risk-need factors.

The manner in which treatment is provided falls under the "responsivity" principle. Sex offender treatment will occur in the context of a therapeutic community, utilizing weekly groups. Group content will be primarily psychoeducational and cognitive-behavioral in nature. MHM has found that providing sex offender treatment services to general population offenders creates concerns about confidentiality, safety, and risk to the offenders concerning personal material discussed in groups. As a result, individual offenders are hesitant to provide personal information to their peers in a general population setting. To help address these concerns, MHM's sex offender treatment groups will be referred to as "Special Treatment Groups" rather than "Sex Offender Treatment Groups." Treatment in these situations will be focused on providing primarily didactic educational materials in a group setting. Individual offenders are asked to utilize the materials from each group and apply the concepts to their own identified risk-needs through the use of homework and journaling.

As failure to participate in or complete sex offender treatment is likely to affect parole conditions or other release considerations, accommodations for special offender populations may need to be considered. Accommodations for providing services to offenders housed in segregation may be possible if staffing and security concerns allow for individualized treatment with these offenders. Often, the highest risk (and thus most dangerous) offenders are the most difficult to treat due to behavioral impulsivity and refusal to participate.

MHM will propose a procedure for collaborating with mental health staff for the inclusion of offenders with serious mental illness. As sex offender treatment is a cognitive process, it may be that some mentally ill offenders cannot benefit from or participate in treatment during acute episodes of illness or due to chronic psychiatric instability. MHM will work with the DDOC to create a process for assessing and "excusing" offenders who are not able to participate in groups due to psychiatric illness. A parallel process may be necessary for offenders with physical illness. Collaboration with mental health staff and medical staff

will be ongoing for offenders with serious physical conditions and accommodations may be provided as indicated.

MHM understands that sex offender treatment will need to be provided as directed by the DDOC BHCS and the Courts. MHM's proposed general population sex offender "Special Treatment Groups" will include six treatment units designed to address each dynamic risk factor. Sex offenders with 12 – 18 months remaining on their sentence will be prioritized for enrollment in the Special Treatment Group program. Initial group size will be 16 – 20 offenders, given probable attrition rates

Offenders' risk factors will be addressed through psychoeducational, cognitive-behavioral, skills-building, and relapse-prevention modalities using best practice models. Brief descriptions of each proposed treatment unit and the modules that comprise them are described below:

Unit One – Assessment and Orientation (5 modules)

- Confidentiality and limits – treatment agreement
- Psychosocial assessment and history
- Assessment of dynamic risk factors through a pre-treatment questionnaire
- Orientation to general population sex offender treatment
- Overview of sex offending behavior and the relapse prevention model

Unit Two – Managing Your Behavior (12 modules)

- Pre-unit assessment
- Impulsivity & self control (3 modules)
- Dysfunctional coping (2 modules)
- Developing coping skills (3 modules)
- Post-unit assessment

Unit Three – Emotions and Relationships (12 modules)

- Pre-unit assessment
- Self-concept & negative self-evaluation (2 modules)
- Emotional peers (congruence with children)
- Emotional intimacy with adults (2 modules)
- Labeling emotional experiences (3 modules)
- Grievance thinking
- Post unit assessment

Unit Four – Sexuality and Interests (8 modules)

- Pre-unit assessment
- Sexual thinking and preoccupation
- Sexual attraction and interest

- Changing your thinking
- Healthy sexuality
- Post-unit assessment

Unit Five – Attitudes & Beliefs (8 modules)

- Pre-unit assessment
- Offense-supporting beliefs
- Adversarial attitudes
- Entitlement beliefs
- Changing attitudes and beliefs
- Post-unit assessment

Unit Six – Planning for Release (5 modules)

- Assessment of dynamic risk factors through a post-treatment questionnaire
- Coping in the community
- Relapse prevention planning
- Sex offender registration
- Program completion

Following the first treatment unit, Units Two through Five begin and end with an assessment measure designed to evaluate the offender's learning and progress during treatment. Successful completion of each treatment unit is determined through these assessments, the offender's level of participation in groups, and completion of homework and journaling exercises. Failure to successfully complete a treatment unit may require that the offender repeat the treatment unit prior to beginning Unit Six.

At each facility offering services, MHM proposes that three Special Treatment Groups be offered weekly. The number of Special Treatment Groups offered per week may vary by facility, depending on the size of the sex offender population. To reduce waiting time and maximize accessibility of treatment, Unit One and Unit Six will be offered on an ongoing (continuous) basis at each facility. As a result, any offender who needs to start or complete the program will not have to wait more than five weeks to do so. The other Special Treatment Group Units will be offered on a rotating basis, one at a time. Any offender who has completed Unit One (the Assessment Orientation Unit) can begin treatment with the start of the next scheduled treatment unit. Every offender can complete the Special Treatment Group program in approximately one year's time. MHM understands that treatment for sex offenders who are incarcerated needs to be ongoing and the completion of the Special Treatment Group Program will not preclude offenders from continuing to receive sex offender treatment.

The Sex Offender Treatment Coordinator will be responsible for tracking offenders' progress through treatment and communicating this information to DDOC. All sex offender treatment documentation will be maintained in a secure location at each facility during active treatment. A Special Treatment Group discharge summary will be

completed on every offender at the time of treatment completion, termination, or release from prison. The discharge summary will be provided to DDOC. Coordination with DDOC's Central Victim Services Unit as well as any probation or parole staff is managed by the Sex Offender Treatment Coordinator. Legal processes will need to be considered in determining long-term storage of and access to sex offender treatment records.

Prior to implementation, MHM's Special Treatment Group curricula and treatment questionnaires will be submitted to the DDOC for approval. MHM anticipates initiating sex offender treatment no later than 180 days following initiation of the contract.

PSYCHIATRIC WATCH (PCO)

n) The Mental Health Services Vendor staff shall be responsible for placing and daily assessment for those offenders that the psychiatrist has placed under a Protective Custody Order (PCO). The Vendor must follow DDOC policies as they relate to psychiatric observation and watch.

MHM acknowledges, accepts, and will comply with the above requirements.

MHM will follow DDOC policy in the assessment, admission, treatment, and discharge of offenders into and from Protective Custody Order (PCO) status. Placement of offenders who are at risk for self-harm on psychiatric watch status is one of the key interventions for suicide prevention. As such, MHM has developed thorough staff training and clinical infrastructure to support psychiatric watch procedures and the treatment of offenders placed on watch. We understand how important it is to manage these vital mental health resources efficiently, safely, and according to policy.

Specifically, MHM understands that PCO status includes three levels of observation and that the appropriate level of observation must be indicated at the time the PCO is written. Staff will complete an initial psychiatric observation note that includes an assessment of the offender's risk and a plan of treatment that addresses how the current crisis will be resolved. In completing these assessments and crisis treatment plans, MHM staff will meet all relevant DDOC requirements and NCCHC standards.

Offenders on PCO status will have daily face-to-face assessments and interactions with mental health staff, and progress under the crisis treatment plan will be documented in daily progress notes. Daily assessment will include consultation with correctional officers regarding the offenders' behavior, mood, eating and sleeping patterns, and communications; and this information will be included in the daily progress notes completed by MHM staff. All required observation documentation will be completed as required by DDOC policy. Placement on PCO status will be noted on the offender's Master Problem List.

No offender will be released from PCO status without authorization by a qualified mental health professional. Pursuant to DDOC policy, offenders will be "stepped down" from continuous ("Level I") to close/moderate risk ("Level II") to close/low risk ("Level III") observation status prior to discontinuation of watch status, and must remain a minimum

of 24 hours on each level prior to release from watch status. Consultation with either a psychiatrist or a licensed psychologist will take place at least once prior to discontinuation of suicide watch. In addition, a comprehensive mental health evaluation will be completed for each "step down" precaution level and prior to the offender being released from PCO status. This evaluation will ensure that the suicidal or psychiatric crisis has either been resolved so that the offender can be safely treated at a lower level of care, or has been clearly identified so that intensified mental health treatment can take place at a higher level of care. Multidisciplinary consultation will also be sought prior to discontinuation from watch.

Following release from PCO status, an offender's individual treatment plan will be reviewed and revised as needed in light of the PCO placement. MHM will ensure that PCO follow-up assessments occur within 24 hours, within 7 days and within 21 to 30 days post-release. MHM understands that these assessments must be completed by mental health or trained healthcare staff. If awarded the contract, MHM will work closely with the DDOC and medical vendor to determine the conditions under which trained healthcare staff will conduct these assessments. Upon request, MHM will provide training to healthcare staff in suicide risk and mental health assessment for purposes of these post-watch assessments.

Training

MHM has developed clinical infrastructure and staff training in crisis assessment, crisis treatment planning for offenders requiring watch status, and crisis management interventions. We train staff to look beyond an offender's verbal communications to examine nonverbal communications, contextual clues, and concrete behavioral evidence that the suicidal crisis has been resolved. Release from psychiatric watch status requires reliable evidence that behavioral change has occurred and risk has been reliably reduced. MHM staff are trained to look for specific evidence that risk has been reduced and remains reliably reduced post-release from PCO status. Often, some of the best evidence emerges through consultation with correctional staff.

To ensure quality care, review of psychiatric watches is a regular part of MHM's CQI programming and annual contract compliance reviews conducted by our Clinical Operations Department. These reviews include examination of the length of watch, quality of care while on watch, documentation supporting the need for watch status, crisis treatment planning, ongoing assessment, documentation supporting the appropriateness of discontinuing watch status, and continuity of care following release from watch. All of these areas are of key importance for ensuring offender safety.

Behavioral Management: Extended Lengths of Stay

MHM also understands the challenges of providing appropriate treatment services to offenders who remain on PCO status for extended periods of time. In most cases, offenders with serious mental illness who require PCO status can be carefully transferred to higher or lower levels of care within 72 hours. This may not be the case for offenders with serious personality disorders. Offenders who persist in threatening self-injurious or

suicidal behavior can sometimes be fairly characterized as "holding themselves hostage," neither permitting mental health staff to step them down to lower levels of care nor exhibiting willingness to engage in treatment. Prolonged stays on PCO status with little opportunity to provide targeted treatment may result. This may give rise to the appearance that the primary treatment for such offenders is "time on watch."

We understand just how risky, challenging, and resource-intensive these offender behaviors can be. In every correctional system in which MHM provides services, a small group of offenders with recurrent and severe self-injurious behaviors have taxed mental health staff in outpatient settings and repeatedly required management on psychiatric watch status and/or treatment within licensed or inpatient mental health settings as a result of the severity of their behavior. Often, these offenders have high levels of behavioral impulsivity, anger, alienation, and determination. They are at high risk for suicide or accidental death. They frequently have long segregation sentences due to disciplinary infractions and severe Axis II pathology. Some may also have serious mental illness that contributes to their behavior.

To meet the needs of this high-intensity offender group, MHM has developed a company-wide behavior management program. This program includes functional assessment of problem behaviors; intensive risk assessment; multidisciplinary collaboration and treatment to include pharmacotherapy; psychoeducational programming; and cognitive-behavioral interventions to reduce and eventually eliminate maladaptive behaviors. These efforts have successfully reduced lengths of psychiatric watches and reduced the number of watches these offenders require.

MHM's behavior management interventions are supported by a thorough clinical infrastructure. Detailed policy and procedures have been developed to guide interventions, support offender autonomy and rights, and avoid abusive or punitive responses to problem behaviors. We have a library of behavior management templates and strategies to draw upon. Guidelines for multidisciplinary collaboration include all disciplines of mental health, medical staff, security staff, and facility administration. We ensure that self-injurious offenders receive prompt emergency medical care as clinically indicated, but also strive to provide this care in manner that minimizes "secondary gain" and inadvertent reinforcement of the problem behavior.

MHM's behavioral management initiatives include more than rewarding offenders for the absence of unwanted behaviors. All too often, behaviorally disturbed offenders are simply expected to stop unwanted behaviors, with the promise of a reward after a set amount of time. For many offenders, such expectations are unrealistic. MHM utilizes empirically supported cognitive-behavioral interventions to build desired skills in this population. We also have developed in-cell psychoeducational programming and structured group curricula to engage self-injurious offenders in developing a menu of replacement behaviors. Many of the interventions developed within Dialectical Behavior Therapy are included in this programming.

Staff training modules in de-escalation and behavioral interventions, conducting functional assessments, ethical guidelines in behavior management, and working with

staff have been developed. This training has been tested and found effective in multiple correctional settings. Day-long behavior management workshops have been provided to multidisciplinary staff working in secure inpatient mental health settings. MHM includes security staff in its training sessions to ensure consistency in approach and collaborative communication across discipline. Our experience is that safety cannot be assured unless correctional officers are included in the multidisciplinary treatment team and in unified approaches to behavioral disturbances.

While the goal of MHM's clinical infrastructure is to develop local behavioral expertise within every correctional system, a team of behavioral consultants is also available through MHM's Clinical Operations Department. These consultants provide functional and risk assessment and behavioral planning assistance for high-risk, high-profile, "treatment resistant" offenders. To date, such behavioral consultations have been provided in state correctional systems in Alabama, Florida, Maryland, Massachusetts, Pennsylvania, and Tennessee.

In developing behavior management plans, behavioral specialists work closely with psychiatric staff to ensure that pharmacological interventions are not overlooked or overused. Psychotropic medications often temper behavioral impulsivity and emotional reactivity and can assist offenders in maintaining behavioral control. On the other hand, offenders may engage in self-injury in an attempt to access preferred medications and/or as part of a larger pattern of exaggerating or feigning mental illness. MHM clinical leadership has extensive experience with the assessment of mental illness and determination of treatment needs.

INITIAL MENTAL HEALTH ASSESSMENTS FOR SEGREGATION

o) Correctional staff will inform Medical Services Vendor's staff when an offender is placed in segregation. The offender's medical record will be reviewed prior to or within one (1) hour of notification of placement in segregation for medical, dental or mental health conditions by Medical Services Vendor staff. Those offenders found to have conditions which would be contradictory to confinement or would require special accommodations will be identified by a medical provider. Offenders with mental illness will be referred to an appropriate mental health provider for evaluation. The Medical Services and Mental Health Services Vendor will follow DDOC policy E-09, Segregated Offenders, and NCCHC standards. All offenders being transferred to segregation will have a mental health and medical evaluation prior to transfer or within one (1) hour of transfer.

MHM acknowledges, accepts, and will comply with the above requirements.

We understand the risks and ethical concerns raised by the prospect of confining inmates with serious mental illness to segregation based on behaviors that were the result of mental illness. As mentioned previously, MHM understands that mental health staff will be notified by medical staff through DACS when offenders with serious mental illness (either current or treated within the last five years) are placed in segregation. Mental health staff will assess these offenders within one hour of notification of the segregation placement.

This assessment will be completed in a private interview setting, according to DDOC policy and procedure, using the DDOC's Initial Mental Health Segregation Assessment form.

Immediately following completion of the Initial Mental Health Segregation Assessment, qualified mental health staff will also provide mental health consultation to the disciplinary process for these offenders, when disciplinary charges were the cause of the offenders' placement in segregation. Again, MHM staff will conduct this consultation and review of disciplinary charges according to DDOC policy.

MHM understands that the medical vendor is responsible for identifying offenders for whom segregation placement may be contraindicated due to particular conditions. However, the determination that segregation may be contraindicated due to mental health reasons requires specialized training, and MHM is pleased that the DDOC's mental health consultation to the disciplinary process includes evaluation of whether the offender is able to tolerate confinement in segregation. This review will include assessment of the following:

- Whether the offender suffers from a mental illness
- Whether the offender understands the disciplinary charges
- Whether the offender is able to understand the disciplinary hearing and participate in it meaningfully, including whether the offender can defend himself/herself
- Whether the offender's mental illness contributed to the behavior that resulted in the disciplinary charges
- Whether the offender is unlikely to be able to tolerate confinement in segregation without deterioration in mental health
- What alternative sanctions might be considered in the event the offender is found guilty of the disciplinary infraction but unable to tolerate segregation

This mental health consultation to the disciplinary process will be completed according to DDOC timeframes using the required Mental Health Review of Disciplinary Charges form. Due to the specialized and complex nature of this assessment, and the need to complete it promptly, MHM has developed both model Policy and Procedures and a separate Clinical Guidelines to support staff in completing this assessment. Our Guidelines are attached as **Attachment J**, and may be revised to meet the needs of DDOC.

MHM's practices of conducting mental health rounds, period evaluations, and continuing treatment for mentally ill offenders in segregation is discussed earlier in this proposal. MHM will ensure that all mental health services delivered in segregation meet DDOC and NCCHC standards.

CONFIDENTIALITY

p) The Vendor will ensure that offender health information is handled in accordance with procedures established by Federal and State confidentiality of health information

laws and regulations. Vendor's clinical staff shall readily have access to health records produced, or in the possession of, the Medical Services Vendor on behalf of DDOC.

MHM acknowledges, accepts, and will comply with the above requirements.

We are sensitive to the confidentiality requirements of correctional mental health services. MHM is committed to providing mental health services for offenders that respect the dignity of the individual by maintaining confidentiality of information, records, and mental health contacts. MHM staff follow HIPAA guidelines, NCCHC standards, and ACA standards related to confidentiality. Our staff will also follow the Department's specific confidentiality requirements and will receive no less than annual in-service training on the rules for confidentiality and the confidential management of offender clinical information and documents. Offenders are advised of the limits of confidentiality prior to engaging in assessment or treatment.

The responsibility for maintenance of the medical record is a joint medical/mental health responsibility. It is expected that most of the responsibility will lie with the medical vendor. MHM will ensure the timely entry of mental health information utilizing the approved forms and format as required by DDOC. All documents containing confidential offender information will be handled and stored in a secure fashion.

TECHNICAL ASSISTANCE & TRAINING

q) Technical Assistance and Training (if applicable)
The Mental Health Services Vendor shall provide suicide prevention training for DDOC staff; managing special mental health populations training for DDOC staff as appropriate, including biennial updates; Vendor's shall submit mental health training curricula to the Bureau Chief for review and approval at least 30 days in advance of intended training.

MHM acknowledges, accepts, and will comply with the above requirements.

We have found that conducting training with correctional officers and medical staff in mental health issues, particularly when there is change in practice or a new program is being implemented, is essential to ensuring a successful mental health program. These trainings are not only important for sharing information but also for developing rapport among correctional, medical, and mental health staff. MHM has developed a "library" of staff training modules that far exceed those required by NCCHC or ACA. Each of the training modules includes a trainer outline, trainee handout, PowerPoint presentation, trainee post test and training evaluation, and trainee post-test answer key.

A list of the MHM training programs currently available for security, medical, and mental health staff follows:

- Suicide Prevention

- Introduction to Mental Disorders
- Types of Mental Illness
- Mental Illness in Corrections
- Management and Treatment of Offenders with Serious Mental Illness
- Mental Retardation
- Working with Incarcerated Women
- Confidentiality in Corrections
- Therapeutic Communication
- Restraint Credentialing
- Behavioral Management and De-Escalation Skills with Aggressive and Self-Injurious Offenders
- Ethics and Behavior Management Principles
- Functional Assessment in Behavior Management
- Principles of Risk Assessment
- Violence Risk Assessment Part 1
- Violence Risk Assessment Part 2 - Prison Violence
- Violence Risk Assessment: Role of Correctional Officers
- Clinical Boundaries and Safe Practices
- BloodBorne Pathogens Exposure Control Plan
- HIPAA Privacy Training – Comprehensive
- HIPAA Privacy Overview
- Introduction to Prison Rape Elimination Act
- PREA Sensitivity Training
- MHM Credentialing Process
- Introduction to Continuous Quality Improvement
- Health Record Documentation
- DSM Multi-Axial Diagnoses: Introduction
- Diagnostic Training Series (25 Trainings)
- Treatment Planning: Introduction
- Creating a Multidisciplinary Treatment Plan
- Treatment Goals and Interventions
- Documenting Progress under a Treatment Plan
- Reviewing and Updating Treatment Plans
- Creating a Crisis Intervention Treatment Plan
- Documenting on the Problem List
- Developing Recovery-Oriented Treatment Plans
- Psychotropic Medication
- AIMS Testing

- Conducting Groups in Corrections
- Addressing Sleep Disturbance in Correctional Setting
- Trauma Treatment: Part I - Post Traumatic Stress Disorder and Complex Post Traumatic Stress Disorder
- Trauma Treatment Part II: Trauma-Informed
- Trauma Treatment Part III: Gender-Responsive Treatment
- Sex Offender Programming
- Malingering and the M-FAST
- Therapeutic Response to Malingering
- Structuring and Formatting Continuous Quality Improvement Reports
- Principles of Leadership
- Principles of Management

Our training programs are flexible and tailored to meet the specific needs of the client. Appreciating that it can be difficult to schedule correctional officers for extensive training, MHM has developed handouts related to the risks for self-harm among offenders to be used for brief "refresher" training of correctional officers during roll call.

Upon contract award, MHM will submit the developed training curriculum for review by the DDOC. We will collaborate with the DDOC in tailoring the correctional officer training to the system's needs and will develop an annual schedule for correctional officer training. Similarly, we will collaborate with the DDOC and the medical vendor to establish a training program and schedule for medical staff.

When selecting a mental health contractor, the ability of the contractor to provide technical services should be considered. MHM is uniquely qualified to provide consultation services on a variety of topics, including achieving compliance with consent decrees; developing specialized mental health programs, construction planning, facility staffing plans, and legislative issues. MHM provides consultation services at no additional cost to the client. We are confident that the correctional mental health expertise shared among MHM staff cannot be matched.

MHM's corporate and contract-specific staff are recognized by correctional mental health experts for their skills in the following areas:

- Resolution of court-mandated or federal monitoring
- Violence and suicide risk assessment
- Formulary management and development of treatment guidelines for mental illness
- Behavior management programs for individual offenders
- Behavior management units for offenders with extensive history of self-injury
- Specialized units for offenders with serious mental illness and significant behavioral disturbances requiring restrictive housing
- Gender-specific programming for female offenders

- Collaboration in development of mental health policies and protocols
- Development of comprehensive Continuous Quality Improvement programming
- Comprehensive and transparent monitoring of compliance with contractual requirements and agency/community standards in the delivery of services
- Operation of correctional/forensic psychiatric hospital settings achieving accreditation from the Joint Commission and/or licensure/certification from the state's Department of Health Services

RESOLUTION OF DISPUTES

r) Resolution of disputes shall be a cooperative effort. The Vendor's Mental Health Administrator shall be the lead for daily problem resolution. The DDOC Mental Health Treatment Administrator, BCHS shall lead the State's problem solving efforts and shall include any of the Mental Health Services Vendor's staff, other Vendor staff, or DDOC staff as is needed to facilitate problem resolution. It is expected that problems will be quickly resolved as a matter of administrative efficiency and responsiveness. Administrative responsiveness is an important criteria for evaluation considered at contract extension.

MHM acknowledges, accepts, and will comply with the above requirements.

MHM takes pride in the partnerships that have developed with our current clients as well as our reputation for timely and effective responses to identified problems. Our goal will be to maintain open communication with the DDOC Mental Health Treatment Administrator and the DDOC management and security staff at each facility. To achieve this goal, MHM staff will engage in problem-solving with all stakeholders when an issue arises. While the MHM Program Manager will be the primary contact when there is a systemic issue or offender-specific issue, onsite MHM clinical staff and corporate support staff will participate in problem resolution when needed. Any and all problems will be quickly addressed and resolved to prevent any disruption in the program.

MHM will establish informal as well as formal communication with the medical vendor to promote an on-going collaborative relationship. The MHM Program Manager will be responsible for establishing routine lines of communication and developing procedures to ensure that ongoing coordination of services occurs. Further, the MHM Medical Director will maintain open communication with the medical services Medical Director for joint problem-solving of clinical issues. When an offender is being treated for both physical and mental health problems, MHM staff will participate in joint treatment planning with the medical staff.

MEDICAL PEER REVIEW & CONTINUOUS QUALITY IMPROVEMENT

s) Medical peer review shall be conducted quarterly and shall be defined by the Bureau Chief. Vendor's mental health staff shall participate in the peer review

process and discuss findings with facility managers. Vendor's Clinical Administrator shall work cooperatively with the DDOC, and any other DDOC Vendors, to establish and maintain a viable Continuous Quality Improvement System (CQIS). Please see 24 *Del. C.* § 1768 regarding the State of Delaware's statutory peer review privilege.

MHM acknowledges, accepts, and will comply with the above requirements.

MHM is committed to ensuring implementation of a strong quality improvement process. In current contracts, we cooperate in the implementation of the client's Continuous Quality Improvement (CQI) program as well as the CQI program of the medical vendor. We are an active member of the CQI programs conducted system-wide and at each facility and collect all information and statistics requested. MHM also conducts an internal CQI program to complement the client's and medical vendor's CQI programs. The MHM internal CQI program offers a forum in which mental health issues are the primary focus. Findings and recommendations from the MHM CQI program are regularly shared with the other CQI programs.

MHM's CQI programs have facilitated improvements in quality of care in the following key areas, among others:

- Reduction in the duration and frequency with which therapeutic restraints are required
- Reduction in polypharmacy and use of emergency involuntary medication
- Improvement in diagnostic accuracy
- Improvements in access to care
- Improvements in continuity of care at reception and release
- Improvements in nursing and psychiatric documentation

MHM has developed a Model CQI program that is tailored to the unique requirements of the client. MHM believes that mental health services are improved through an ongoing examination of processes, procedures and data by a multidisciplinary team of staff who perform the services. The MHM Model CQI program includes the structure of the CQI Committee, the types of studies to be conducted, and an annual peer review process.

For further information on our CQI program, please refer to *Tab 3,Section II.B.4 vii* and *Tab 4, Section X, C.8.*

PERFORMANCE MANAGEMENT

t) Mental health programs shall reflect generally accepted professional standards. The Mental Health Services Vendor's Mental Health Administrator and staff working within each facility shall be responsible for keeping and reporting data necessary for evaluating all programs/services provided. Measurable outcome criteria shall be established that serves as key indicators that mental health generally accepted

professional standards are established and maintained. Vendor's Mental Health Administrator shall work cooperatively with the Bureau Chief and the and any other DDOC Vendors to identify and implement mental health generally accepted professional standards that are appropriate to address offender mental health issues consistent with applicable DDOC policies and NCCHC standards. Statistics indicating that programs/services are meeting the measurable outcome criteria shall be produced by the Vendor on a monthly basis in a form and format that meets DDOC requirements See Appendix D, Performance Monitoring to this agreement.

MHM acknowledges, accepts, and will comply with the above requirements.

We provide mental health services that comply with applicable state and federal laws and are consistent with NCCHC and ACA standards. ***Our success rate in meeting accreditation requirements is 100% to date.*** Compliance with NCCHC standards is the goal for all MHM contracts even if the client does not require NCCHC accreditation. MHM has developed "model" policies and procedures and related forms for each NCCHC standard. These policies provide guidelines when working with the client in developing contract-specific policies.

Ensuring relevant accreditation for all MHM contracts is the responsibility of MHM's Clinical Operations Department. Because MHM's Vice President of Clinical Operations, Jane Haddad, PsyD, participates in NCCHC's task force for the development and refinement of mental health standards, we are knowledgeable about NCCHC modifications to standards and quickly respond to refinements in these standards. Guidelines to facilitate the accreditation process have been developed to assist onsite staff in understanding various standards and what surveyors will expect to demonstrate compliance with each standard.

Our Clinical Operations Department maintains a roster of institutions indicating potential dates for accreditation reviews. Several months before a survey is scheduled, Clinical Operations staff conduct a pre-survey audit of an institution's mental health program to help identify areas requiring attention. We then assist the site staff in addressing the identified problem areas until confident that compliance has been achieved. This process has proven effective in ensuring accreditation.

MHM appreciates DDOC requirements to monitor mental health service delivery on a monthly basis through the submission of monthly service delivery and incident statistics. Upon contract award, Clinical Operations staff will collaborate with the Bureau Chief, relevant DDOC administrative staff, and other healthcare vendor staff in developing the criteria to be monitored and the format in which to report the statistics. MHM is intimately familiar with this process since all current MHM contracts include this expectation.

MHM recently initiated a company-wide program to measure the effectiveness of group programming conducted by our staff. Several pilot studies were completed prior to choosing the current pre and post test process. These outcome measures are discussed

earlier in the proposal. We look forward to implementing them and sharing the results with the DDOC.

In addition to offering an internal CQI process and maintaining accreditation, MHM has developed a *contract compliance audit* process to ensure that we are achieving the contractual requirements of the specific contract. Contract compliance audits are conducted by a team of mental health clinicians from the MHM Clinical Operations Department. MHM began conducting contract compliance audits in 2005. This process has proven effective in identifying not only obvious areas for potential performance improvements but also in identifying contractual requirements that may be neglected in the day-to-day contract implementation. Contract compliance audits have also identified best practices and treatment efficiencies within particular contracts that are then shared across our other contracts.

When MHM is awarded a contract, Clinical Operations' staff completes the *contract compliance indicators* document. These indicators include all the clinical, personnel, credentialing, training, reporting, CQI, and other requirements referenced in the MHM-client contract, the client's Request for Proposals, MHM's proposal, relevant court orders or memoranda of agreement with monitoring agencies, and the client's policies and procedures. The DDOC's Performance Indicators would be an essential component of the information collected. The document is organized by noting overall expectations and then dividing the information into sections related to staffing, intake, outpatient services, psychiatric follow-up, crisis intervention, mental health units, discharge planning, documentation, etc. This document is provided to the Program Manager and other supervisory staff prior to contract implementation to ensure that there is a full understanding of the contractual requirements.

Clinical Operations staff are available to provide assistance prior to contract start-up and during the implementation period to ensure the structure is present to meet contractual requirements. The first contract compliance audit, conducted about 180 days after contract start-up, is focused on identifying contractual issues that should receive priority attention.

Follow-up contract compliance audits are conducted annually and more frequently if a contract is having performance issues or upon client request. These audits include meetings with the client, mental health, and medical leadership; meetings with mental health line staff and correctional officers; review of program documentation; review of mental health documentation; and observation of actual clinical interventions. When contract compliance audits are completed for contracts with multiple sites, part of the audit is conducted at the Regional Office with review of institutional operations conducted at the sites selected by the client. Some clients request audits at each site while others focus on sites with major mental health services. Our process is unique in that at the end of the audit, Clinical Operations staff meet with the client to share initial impressions.

Subsequently, a contract compliance report based on audit findings is developed. The report identifies strengths and weaknesses in the program and provides recommendations to address areas for improvement. The client, MHM leadership in the contract, and MHM corporate management are provided a copy of the report. MHM's regional leadership then uses the report to develop corrective action plans. Our experience has been that contract compliance reports have fostered growth and improved quality of services in every contract. The process has been well-received by our clients due to the transparency, integrity, and thoroughness of the audits and reports.

MHM's goal is to ensure that the mental health services our staff provide are consistent with contractual expectations and community standards through our attention to the accreditation process, our internal CQI program, and our contract compliance audits. We are willing to explore additional ways to measure our contractual performance with the DDOC. We understand that achieving and maintaining compliance with the Department of Justice agreement is of paramount importance to the DDOC, and MHM is highly qualified to assist the DDOC in reaching these goals.

TELEMEDICINE SUPPORT

u) All on-site Vendor's clinical providers and ancillary staff, and all off-site specially engaged by the Specialty Consultation Vendor shall support the use of telemedicine as required by the DDOC to reduce the incidence of offender travel. The Vendor is encouraged to include a severable proposal for enhanced statewide telemedicine capability and usage which meets generally acceptable professional standards for the delivery of health care services. Such proposal shall include locations and areas in which telemedicine may be appropriately utilized, the anticipated usage of such technology, the necessary hardware and software to implement such a system, and a proposed timeframe for completion of all work necessary to fully implement the proposed system. The proposal must be consistent with Department of Technology and Information requirements.

MHM acknowledges, accepts, and will comply with the above requirements.

Telepsychiatry

With regard to telemedicine (or as it pertains to mental health services, *telepsychiatry)*, MHM is fully dedicated to providing quality and timely mental health services to offenders confined to correctional facilities, regardless of the location of those facilities or the special needs of the individual offender. MHM has developed a state-of-the-art process for delivering psychiatric services via telepsychiatry to locations where psychiatric staffing may be limited or where offenders with special needs (e.g., deaf, non-English speaking) cannot be treated by on-site staff.

MHM is a partner with our clients in the delivery of safe, effective, and confidential psychiatric services via telepsychiatry. We have found telepsychiatry to be effective in reducing and addressing behavioral emergencies and supplementing on-site care. Where

we have tested prototype applications of telepsychiatry for correctional mental health programs, the most common applications are as follows:

- Psychiatric interview, medication monitoring, and certain psychiatric evaluations
- Multidisciplinary team meetings for individual treatment planning
- Offender interview and assessment following discharge from the mental health unit

We do not foresee nor intend for telepsychiatry to fully replace onsite psychiatric visits. The psychiatrists who utilize this technology continue to make regular site visits to their assigned prisons.

MHM has successfully integrated the use of this technology in our Georgia and Alabama prison programs and the popularity of this service is growing exponentially. Though our preference is to provide psychiatric services on site through face-to-face encounters, and our recruiting capabilities allow us to succeed in staffing where others fail, we are finding a number of benefits to using telepsychiatry that go beyond the obvious staffing and convenience issues as follows:

1. **Increased Efficiency** – Psychiatrists using telepsychiatry tell us they are more focused on the offenders and that their productivity has increased between 10%-36%. The telepsychiatry clinics are now functioning more like clinics in other medical specialties, where productivity is maximized by the use of support staff.

2. **Increased Access** – We found that we are better able to increase overall access to psychiatrists by making "on-demand" services available. For example, prisons that may have traditionally only been served on-site periodically (i.e. weekly, monthly) by psychiatrists can now have ready access to psychiatrists between scheduled on-site visits via telepsychiatry. With our Georgia telepsychiatry clinics now operating on a daily basis, every prison now has near constant access to live psychiatry services.

3. **Better "Fit" Between Clinician and Offender –** We have found that work satisfaction has improved for psychiatrists using telepsychiatry. The psychiatrists like this scheduling flexibility, the off-site office environment and the better organization of telepsychiatry clinics as well as being able to respond in a more timely way to offender mental health needs. In addition, remote sites now have better access to quality clinicians that meet the varied needs of the offenders.

4. **Fewer Transfers for Urgent Care –** By increasing the frequency in on-demand clinician presence, many transfers to urgent care facilities have been avoided. When urgent situations arise, psychiatric staff can interview offenders outside of normal business hours, and decisions can be made without extra offsite trips being made.

Outcomes in Georgia

MHM's telepsychiatry clinics in Georgia continue to meet and exceed our expectations in terms of offender satisfaction, desired outcome, and overall efficiency. The development of this program has been an important component of MHM's ongoing efforts to accomplish our current cost containment goals without a reduction in the vital access to care and service.

In a recent comparison of the average number of satisfactory contacts completed in an eight-hour shift in a telepsychiatry clinic versus a traditional model, we found the clinicians to be significantly more productive under telepsychiatry. *As mentioned above, an internal review of over 600 telepsychiatry contacts in the Georgia Department of Corrections in February 2009 found the number of offenders seen compared to a conventional clinic was 10% to 36% greater with no reduction in satisfaction or desired outcome.*

We are now conducting approximately 1,000 offender encounters per month in our Georgia program using telepsychiatry.

Implementation for the DDOC

Our clinical staff have extensive experience working with telemedicine and telepsychiatry services. We have several psychiatrists who have been using this technology for many years as well as IT specialists and a nurse coordinator who go on site to new facilities to establish telemedicine programs, train staff, and develop operational procedures for services. We maintain a full-time Telemedicine Coordinator in our Atlanta regional office to aid in the implementation of telemedicine in our contracts; and because we are seeing significant growth in this segment of our business, we will likely continue to expand the corporate and regional resources for this service as it grows in the coming years.

MHM will work with the DDOC to create policies and procedures for managing, transmitting, and storing clinical information in compliance with HIPAA regulations as well as the needs of each facility for which telepsychiatry is considered. Support from Clinical Operations staff, managers from other contracts, and Medical Directors currently utilizing telepsychiatry are available for consultation. MHM's Clinical Operations Department currently employs a full-time IT staff member dedicated to telepsychiatry services as well as Dr. Beltran Pages, former Medical Director for MHM in Florida, who in addition to other roles will be serving as MHM clinical leader for our telepsychiatry services. Dr. Pages will be made available to the DDOC program as a trainer and peer resource for psychiatrists providing telepsychiatry services in Delaware.

MHM agrees to take all reasonable efforts to ensure that mental health services are provided on site, so as to minimize any risk to the public resulting from transportation for off-site treatment. As just discussed, the use of telepsychiatry services has proven an effective way of linking offenders in behavioral crises with treatment staff, thereby reducing the need for off-site or inter-facility transfers for mental health purposes. We

anticipate using telepsychiatry at most locations when needed, and will meet with the DDOC to establish a timeframe for implementation.

Telepsychiatry Equipment

MHM understands that the use of telepsychiatry will require MHM to purchase and maintain any necessary equipment. There are numerous options for establishing remote televideo connections. These range from high-end telemedicine suites that utilize dedicated fiber-optic connections between locations to transmit images (including endoscopic images) and audio of the highest quality to low cost, web-based applications that are sufficient for psychiatry services. The portability of web-based systems and improvements in image quality have greatly expanded the capabilities for using telepsychiatry in prisons where offender transport is an issue. We are currently having great success using desktop and laptop computers that can be utilized virtually anywhere in a prison setting to link offenders with psychiatrists. We have even been successful using wireless computer communication technology to connect remote housing units to outside psychiatrists and mobile psychiatrists to prison facilities.

NCCHC Accreditation

v) The Vendor is required to obtain and/or maintain NCCHC accreditation for each and every current and future facility in whole and as to each part in the DDOC. DDOC intends to include specific liquidated damages in the contract between DDOC and the Vendor for any failure to attain and/or maintain such certifications and/or accreditations. The beginning and ending dates of the penalty will be governed by any written communication from the NCCHC. Any date within any calendar month will serve as the beginning and ending dates and each inclusive month, (first, intermediate, and last) of non-accreditation will be assessed the penalty. Any assessed liquidated damages will bear the appropriate legal relationship to the actual harm caused DDOC. Liquidated damages shall not be the exclusive remedy for failure to achieve and/or maintain accreditation.

MHM acknowledges, accepts, and will comply with the above requirements.

A key issue for many of our correctional client agencies is the achievement and maintenance of accreditation by the National Commission on Correctional Health Care (NCCHC) and/or the American Correctional Association (ACA). The accreditation standards of each of these organizational bodies include specific requirements for mental health services. Routinely, we assist our client agencies in achieving or maintaining ACA and/or NCCHC accreditation, and ensure our service approach meets accreditation standards. MHM has expertise in meeting national accreditation guidelines for correctional health and complying with state-specific directives and policies. ***Our success rate in meeting accreditation requirements is 100% to date.***

For further information regarding accreditation, please refer to *Tab 2, Section III, B.1.c.*

Mental Health Staffing

Position	FTEs
Activity Tech	3.50
Clerk/Med Records Clerk/MH Clerk	4.50
NP/PA	1.00
MH Director	4.00
MH PHD Psychologist	1.00
MH Worker	18.32
MSW/MH Prof/MHW Super.	7.60
Psychiatrist	4.10
MH Clerk/Observer	7.00
Program Manager	1.00
Regional Psychologist	1.00
Regional Psych Director	0.20
Regional Administrative Assistant	1.00
Sex Offender Treatment Coordinator	2.00
Regional Director	0.25
Total Staff	56.47

Delaware DOC Proposal: Applicable NCCHC Standards and DDOC Policies
Mental Health Services

	RFP Requirement	NCCHC Standards	DDOC Policies
A	Provide a clinical and administrative supervisor	▪ P-A-02/J-A-02 ▪ P-A-03/J-A-03 ▪ P-C-02/J-C-02	▪ DDOC Policy 11-A-02, Responsible Health Authority ▪ DDOC Policy 11-A-03, Medical Autonomy ▪ DDOC Policy 11-C-02, Clinical Performance Enhancement ▪ DDOC Policy 11-C-02.1, Clinical Review for Mental Health
B	Perform assessments, including assessment of inmate's capacity to make informed medical decisions	▪ P-E-05/J-E-05 ▪ P-I-02/J-I-02 ▪ P-I-04/J-I-04	▪ DDOC Policy 11-E-05, Mental Health Screening and Evaluation ▪ DDOC Policy 11-I-02.1, Non-Emergency Involuntary Medication Administration ▪ DDOC Policy 11-I-04, End of Life Decisions
C	Ensure staff use DACS and provide follow-up training re same	*None*	▪ DDOC Policy 11-E-02, Receiving Screening – Intake
D	Provide case management for offenders with histories/symptoms of mental illness	▪ P-G-01/J-G-01	▪ DDOC Policy 11-G-01, Chronic Care
E	1. Be available to all offenders 2. Be available to DDOC staff and participate on review committees 3. Conduct training for other vendor and DDOC staff on mental health issues	▪ P-A-01/J-A-01 ▪ P-A-04/J-A-04 ▪ P-A-05/J-A-05 ▪ P-A-10/J-A-10 ▪ P-C-04/J-C-04 ▪ P-G-04/J-G-04	▪ DDOC Policy 11-A-01, Access to Care ▪ DDOC Policy 11-A-04, Administrative Meetings and Reports ▪ DDOC Policy 11-A-04.1, Staff Meetings ▪ DDOC Policy 11-A-10.1, Mortality and Morbidity Reviews ▪ DDOC Policy 11-G-04, Mental Health Services ▪ DDOC Policy 11-C-04, Training for Correctional Officers
F	Coordinate with DDOC in training and adhere to DDOC suicide prevention procedures	▪ P-C-04/J-C-04 ▪ P-E-02/J-E-02 ▪ P-E-05/J-E-04 ▪ P-G-05/J-G-05	▪ DDOC Policy 11-C-04, Training for Correctional Officers ▪ DDOC Policy 11-G-05, Suicide Prevention, Policies and Procedures

	RFP Requirement	NCCHC Standards	DDOC Policies
G	1. Conduct initial assessment and orientation to MH services 2. Provide a primary therapist 3. Provide individualized 1:1 treatment and d/c planning 4. Groups as indicated 5. Treatment in segregation	▪ P-C-07/J-C-07 ▪ P-E-01/J-E-01 ▪ P-E-02/J-E-02 ▪ P-E-09/J-E-09 ▪ P-E-13/J-E-13 ▪ P-G-02/J-G-02 ▪ P-G-04/J-G-04	▪ DDOC Policy 11-C-07, Staffing ▪ DDOC Policy 11-E-01, Information on Health Services ▪ DDOC Policy 11-E-02, Receiving Screening – Intake ▪ DDOC Policy 11-E-09, Segregated Offenders ▪ DDOC Policy 11-E-13, Discharge Planning ▪ DDOC Policy 11-G-02.1, Mental Health Treatment Plan ▪ DDOC Policy 11-G-04, Mental Health Services
H	1. Conduct initial intake MH screening and refer as needed 2. Complete comprehensive MH evaluation within 24 hours if positive on screening	▪ P-E-02/J-E-02 ▪ P-E-05/J-E-05	▪ DDOC Policy 11-E-02, Receiving Screening – Intake ▪ DDOC Policy 11-E-05, Mental Health Screening and Evaluation
I	Develop individualized treatment plans through the Interdisciplinary Treatment Team	▪ P-G-01/J-G-01 ▪ P-G-02/J-G-02 ▪ P-G-08/J-G-08	▪ DDOC Policy 11-G-02, Special Needs Treatment Plan ▪ DDOC Policy 11-G-02.1, Mental Health Treatment Plan ▪ DDOC Policy 11-G-01, Chronic Care ▪ DDOC Policy 11-G-08, Offenders with Alcohol and Other Drug Problems
J	Provide orientation and training to medical vendor nursing staff in psychotropics and supporting medication compliance	▪ P-A-08/J-A-08 ▪ P-C-05/J-C-05 ▪ P-D-02/J-D-02 ▪ P-D-04/J-D-04	▪ DDOC Policy 11-C-05, Medication Administration Training ▪ DDOC Policy 11-D-02.1, Temperature Sensitive Medications ▪ DDOC Policy 11-2-02.2, Transcription of Medical and Telephone Orders ▪ DDOC Policy 11-2-02.3, Medication Administration Record ▪ DDOC Policy 11-2-02.4, Medication Errors ▪ DDOC Policy 11-D-02.5, Psychotropic Medication ▪ DDOC Policy 11-D-02.6, Monitoring Psychotropic Medication

RFP Requirement		NCCHC Standards	DDOC Policies
K	Participate in Interdisciplinary Treatment Team meetings	▪ P-G-02/J-G-02 ▪ P-G-08/J-G-08	▪ DDOC Policy 11-G-02.1, Mental Health Treatment Plan
L	Support monitoring of offenders undergoing withdrawal from drugs	▪ P-G-06/J-G-06 ▪ P-G-08/J-G-08	▪ DDOC Policy 11-G-02, Intoxication and Withdrawal ▪ DDOC Policy 11-G-08, Offenders with Alcohol and Other Drug Problems
M	Provide sex offender treatment	▪ P-G-04/J-G-04	▪ DDOC Policy 11-G-04, Mental Health Services ▪ DDOC Policy 3-3.7, Registration of Sex Offenders and Community Notification
N	Place offenders on psychiatric watch and assess daily	▪ P-G-05/J-G-05 ▪ P-E-02/J-E-02 ▪ P-E-05/J-E-05	▪ DDOC Policy 11-G-05, Suicide Prevention, Policies and Procedures
O	Assess offenders with mental illness who are placed in segregation	▪ P-E-09/J-E-09 ▪ P-G-05/J-G-05 ▪ P-E-02/J-E-02 ▪ P-E-05/J-E-05	▪ DDOC Policy 11-E-09, Segregated Offenders ▪ DDOC Policy 11-G-05, Suicide Prevention, Policies and Procedures
P	1. Maintain confidentiality of health records 2. Have access to or be in possession of health records during service delivery	▪ P-H-02/J-H-02 ▪ P-H-04/J-H-04	▪ DDOC Policy 11-H-02, Confidentiality of Health Records and Information ▪ DDOC Policy 11-H-04, Availability and Use of Health Records
Q	Provide suicide prevention training and training in management special mental health populations to DDOC staff	▪ P-G-05/J-G-05 ▪ P-E-02/J-E-02 ▪ P-E-05/J-E-05	▪ DDOC Policy 11-G-05, Suicide Prevention, Policies and Procedures
R	Maintain administrative responsiveness for efficient resolution of disputes	▪ P-A-02/J-A-02	▪ DDOC Policy 11-A-02, Responsible Health Authority

	RFP Requirement	NCCHC Standards	DDOC Policies
S	1. Participate in peer review 2. Establish and maintain CQI	▪ P-A-06/J-A-06 ▪ P-C-02/J-C-02	▪ DDOC Policy 11-A-06, Statewide Quality Improvement Program ▪ DDOC Policy 11-A-06.1, Comprehensive Quality Improvement Program, Level 5 ▪ DDOC Policy 11-A-06.2, Comprehensive Quality Improvement Program, Level 4 ▪ DDOC Policy 11-C-02, Clinical Performance Enhancement
T	1. Deliver services according to generally accepted practices 2. Gather and maintain data sufficient to evaluate all services provided, using measurable outcome data	▪ P-G-01/J-G-01 ▪ P-E-12/J-E-12 ▪ P-A-04/J-A-04 ▪ P-A-06/J-A-06	▪ DDOC Policy 11-G-01, Chronic Care ▪ DDOC Policy 11-E-12, Continuity of Care ▪ DDOC Policy 11-A-04.3, Mental Health Services Reports ▪ DDOC Policy 11-A-06.1, Comprehensive Quality Improvement Program, Level 5 ▪ DDOC Policy 11-A-06.2, Comprehensive Quality Improvement Program, Level 4
U	1. Support telemedicine 2. Evaluate need for bridge orders for new intakes within one shift	▪ P-G-04/J-G-04 ▪ P-E-02/J-E-02	▪ DDOC Policy 11-G-04.2, Telepsychiatry ▪ DDOC Policy 11-E-02, Receiving Screening – Intake
V	Obtain and/or maintain NCCHC accreditation at all facilities	▪ P-A-05/J-A-05	▪ DDOC Policy 11-A-05, Policies and Procedures

TAB 6. SUBSTANCE ABUSE TREATMENT SERVICES

SECTION XI. SUBSTANCE ABUSE TREATMENT SERVICES

MHM is excited about the opportunity to provide an enhanced and better managed array of substance abuse treatment services to the Delaware offender population. Our current Maryland DOC correctional mental health program is managed by Dr. Robert "Mike" Hooper, who joined MHM in 2009. Dr. Hooper is well known to the Delaware DOC, having worked in the Delaware system for 25 years, including 15 years managing the substance abuse treatment services. Dr. Hooper has developed a national reputation as an expert in the area of substance abuse habilitation services for offender populations. If awarded the mental health and/or substance abuse programs in Delaware, we will promote Dr. Hooper to a regional director position over our Maryland and Delaware programs, and he will be actively involved in enhancing the substance abuse treatment program and managing services on a daily basis.

A continuum of service will be provided to those offenders who participate in the Key, CREST, and Aftercare programs offered the by MHM for the Delaware Department of Correction. Research by the University of Delaware, Center for Drug and Alcohol Studies on Delaware Department of Correction drug treatment programs has shown that those offenders who participate in an in-prison program, followed by a transitional program and then aftercare, are rearrested *25% less* than those of similar backgrounds but who did not receive in-prison or post-release treatment when measured at 4 to 5 years post release (NIDA Notes, Vol. 20, No 5 (April 2006) by Lori Whitten).

The programs in Delaware have become a model for other correctional systems in the country and are designed to enable offenders to not only successfully cope with their substance abuse issues, but to start thinking about new pro-social lifestyles and taking active steps to achieve them. The structure and discipline in the programs begin to teach the offenders what type of responsibility and accountability is necessary in order to be successful. Simply put, the treatment programs focus on facilitating positive lifestyle changes.

Mission Statement: *Provide a safe environment in which offenders are given the opportunity to learn pro-social cognitive patterns and associated behavioral patterns to return to society and remain crime and substance free.*

A. SCOPE

(A) Scope. Delaware Department of Correction (DDOC) requires substance abuse treatment services for the following programs in Delaware.

- **i. Key North Program at Howard R. Young Correctional Institution in Wilmington, Delaware**
- **ii. Key South Program at Sussex Correctional Institution in Georgetown, Delaware**
- **iii. Key Village Program at Baylor Women Correctional Institution in New**

Castle, Delaware

iv. **CREST North Program at the Plummer Community Correctional Center in Wilmington, Delaware**
v. **CREST Central Program at Morris Community Correctional Center in Dover, Delaware**
vi. **CREST South Program in Sussex Community Correctional Center in Georgetown, Delaware**
vii. **CREST North Program for Women at Women Work Release Treatment Center in New Castle, Delaware**
viii. **6 for 1 Program at Howard R. Young Correctional Institution in Wilmington , Delaware**
ix. **Young Criminal Offender Program at Howard R. Young Correctional Institution Wilmington, Delaware**
x. **Boot Camp Program at Sussex Correctional Institution in Georgetown, Delaware**
xi. **Aftercare Program, statewide**

Vendors must propose services that meet the minimum requirements as specified herein. Services in excess of those required by the DDOC (or in excess of those approved under a final contract) must be in writing and approved in advance by the DDOC.

It is the intent of the DDOC that the successful Vendor provides treatment services to as many individuals as possible, within the parameters of the described scope of services, and within the total funds available for this project. Keeping the treatment beds filled is a priority for DDOC as overcrowding is an ongoing challenge in any prison environment. In conjunction with DDOC's ability to make appropriate referrals and move prisoners to the designated programs, the contract treatment Vendor is responsible for recruitment and must keep the treatment beds filled with appropriate offenders.

MHM acknowledges, accepts, and will comply with the above requirements.

The Delaware substance abuse programs are complex and spread across multiple facilities. Through Dr. Hooper, MHM has a strong working knowledge of these programs and the nuances of each facility. Dr. Hooper's familiarity, plus the strength of our management team, will ensure a smooth transition of the program to MHM with no service lapses.

As mentioned previously, we believe the Key, CREST, and Aftercare continuum is critical for effective substance abuse treatment; and recognize the importance of the 6 for 1 Program and Boot Camp in achieving a quality system of care.

All services MHM provides will be specified in writing and approved in advance by the DDOC.

Filling Treatment Beds

We understand that overcrowding is an ongoing challenge in the prison environment. Therefore, we will ensure that treatment beds are filled through reporting and the weekly monitoring of bed capacity. Additionally, we will maintain a waiting list of offenders who are eligible and wish to enter the program in order to ensure that all possible beds are being utilized.

MHM will recruit offenders for the program proactively in order to meet our goal of providing services to as many eligible individuals as possible. To do so, staff will be assigned to work with DDOC Classification staff and various classification committees to help identify appropriate offenders for treatment. MHM's Case Managers (who will work out of our Regional Office) will also be responsible for working with the Classification Committees at all institutions to help identify appropriate candidates for drug treatment on an ongoing basis. This will help ensure that offenders are placed in treatment in a timely fashion so that the offenders can progress through all phases of treatment prior to re-entry to the community.

Upon DDOC approval, we propose to have offenders who are currently in treatment offer presentations to the inmate populations at various institutions in order to discuss the benefits of joining drug treatment. These presentations are mutually beneficial as it drives interest in the program and gives offenders in treatment the opportunity to apply newly acquired treatment knowledge and recovery skills in the correctional setting.

B. PROGRAM DESCRIPTION

MHM has developed a treatment approach and program design using the latest evidenced-based research available when working with offenders with substance abuse histories. In later sections, we provide detail regarding each of the substance abuse programs (Key, CREST, Aftercare, 6 for 1, Boot Camp, and the Young Criminal Offender Programs). Directly below, we describe our overall treatment approach and program design as it applies to *all components* of the substance abuse programs. This includes the following approaches:

- *Phases of Change*
- Therapeutic Community Treatment
- Interactive Journaling

Phases of Change

The *Phases of Change* (Prochaska, DiClemente and Norcross 1994) will be taught to offenders and staff to develop understanding for how change occurs and what types of intervention processes and strategies are required to facilitate those attempting to change. Our programs are based upon the following principles:

- Change is a universal process

- Change is possible
- All real change is self-change
- The individual is responsible for deciding to make change
- The individual is responsible to do what needs to be done to accomplish change

It is important to underscore with this population that they are *solely* responsible for implementing change. Despite the fact the offenders have made choices resulting in their incarceration, they now have an opportunity to make different choices and change how they behave in the community so that they may remain crime and substance free. MHM staff will serve as role models and facilitate the offender's effort to identify topics to address in order to commence change.

The *Phases of Change* encompasses four distinct stages, namely:

1. Pre-Contemplation
2. Contemplation
3. Preparation
4. Action

Pre-Contemplation

The first of the intervention strategies is Pre-Contemplation which addresses *consciousness raising* (overcoming denial), *social liberation*, and *helping relationships* as offenders begin their treatment experience.

- **Consciousness raising** is accomplished by providing a range of information through interactive journals, presentations, role playing, video tapes, and individual and group counseling. The treatment environment should also post statements, such as the "thought for the day," to provide a positive point of reference.

- **Social liberation**, which is the structuring of one's situation to support the target(s) of change, can be readily accomplished within a prison setting because of the level of control that can be achieved. For example: the "cardinal rules," of the therapeutic community include:

    1. No Violence or Imminent Threats of Bodily Harm
    2. No Possession or Use of Alcohol or Other Drugs nor Refusal to Submit to Urinalysis Testing
    3. No Sexual Misconduct.

  These social expectations support the offender's treatment efforts. A very structured schedule also helps offenders develop routines to assist them in becoming responsible adults.

- **Helping relationships** is a cornerstone to any change effort. In this stage, the offenders begin to learn the rules and routines of the treatment community and

begin to experience consistency (i.e., all offenders are to follow the same rules and routines). As this norm develops, the offenders will be more likely to begin sharing their thoughts and feelings with others. Out of this sharing, relationships will begin to form.

Contemplation

As offenders begin to move into Contemplation, they are able to acknowledge the existence of a problem and staff are able to assist them in targeting problem behaviors. At this stage, additional interventions are recommended such as *emotional arousal* and *self-reevaluation*.

- **Emotional Arousal** is defined as "a significant, often sudden emotional experience related to the problem at hand." (Prochaska et al., 1994. 28). The design of the interactive journals creates opportunities for emotional arousal by focusing on particular targets and events that have affected the offenders' lives.

  Because the central agents of change in the substance abuse program are the offenders themselves, "the opportunities for emotional arousal are numerous. Clients who are further along in the stages of change are more likely to share past experience and future fears with others in treatment." (Hooper 2003, p12-10).

- **Self-Reevaluation** enables the offender "to see when and how [their] problem behavior conflicts with [their] personal values. The result is that [the offender] come[s] not only to believe but truly to feel that life would be significantly better without the problem" (Prochaska et al., 1994 p.29). As part of the interactive journaling, offenders are asked to evaluate "What got me here?" This is an initial attempt to get the offenders to weigh "risk versus outcomes" and begin to think about what different, more positive outcomes could be.

Preparation

As offenders transition into Preparation and begin to plan for change, offenders must make a commitment. The first step is to make the commitment to one's self; the second is to make this commitment publicly in the therapeutic community so that the offender is in a position to be held accountable. With more accountability, it is more likely that needed support can be provided as the offender moves forward to Action.

Action

In the final stage *countering, environmental control,* and *reward* are the additional processes of change to be used.

- **Countering** is "substituting healthy responses for unhealthy ones" (Prochaska et al., 1994, p.30). As the offenders begin participation in the class focused on *Rational Thinking*, they study how to think objectively.

- **Environmental Control** uses interactive journaling so that offenders can assess situations and how they can be changed in order to protect positive outcomes. Another example is having a clear understanding of *People, Places,* and *Things* that are likely to lead to relapse and what must be done to avoid those situations.

- **Rewards** are re-enforcement for positive changes made. Examples in the Prison Residential Treatment setting can be a longer visit with family, a special movie, or a special meal. This emphasizes that positive changes result in positive outcomes.

Recent studies have shown if there is not a Re-entry Program connected with an Aftercare Program, those completing a Key program will not be nearly as successful. Maintenance is an exceptionally important in the treatment process. Given the availability of the 12-Step Programming in the community, offenders are expected to participate in this programming. The last two curriculum modules utilized at the CREST Programs, *Recovery Maintenance* and *Transition*, focus on the necessary steps to be successful in the community.

Therapeutic Community

The therapeutic community can be described as a self-help model in which clients are taught to work with one another and thus become the change agents within the treatment community (DeLeon 1997). While there are two types of Therapeutic Communities, MHM proposes to use the rational authority model, as it is recommended when working with the criminal population (Hooper, 2003, 12-3-12-4). In this model, there is a clear chain of command with MHM staff (in concurrence with DDOC staff) having ultimate responsibility for the types of programming and other activities to occur in any given day.

MHM staff will work with offenders so that they recognize substance abuse as being symptomatic of an underlying, personal problem (as opposed to the drug itself being the problem). **The goal of treatment becomes one of lifestyle change in which offenders are coached to facilitate their efforts to become honest, dependable, productive members of their communities**.

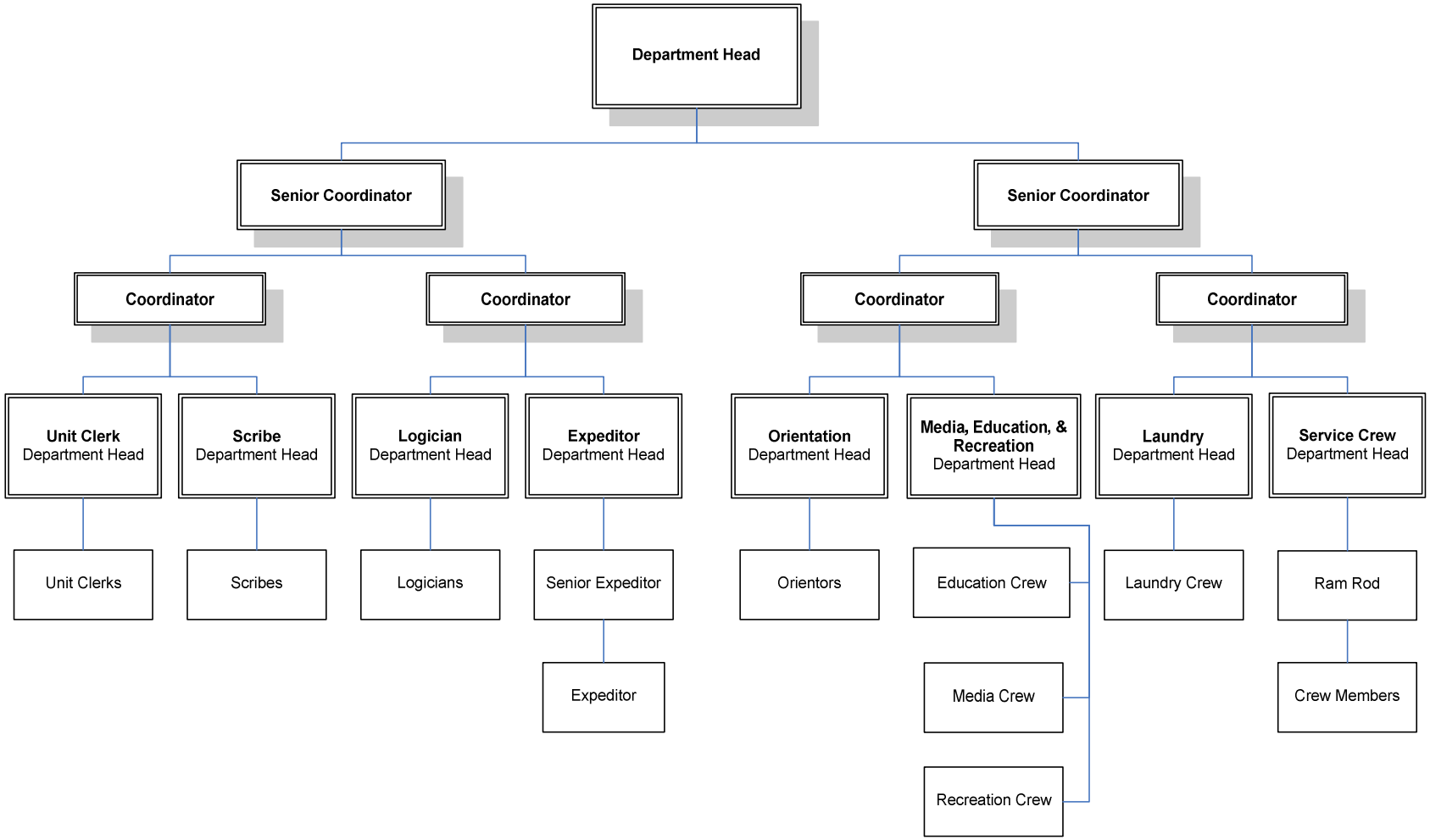
To commence this process of change requires that the offenders learn to live responsibly in their treatment community. Hence, one of the first steps in the treatment program is to provide the offender with *Orientation* (see **Attachment K)** so the individual can begin learning the rules and routines of the community. MHM staff will ensure that offenders are aware of expectations beginning the first day of treatment. One such expectation is that within a short period of time the information in the Orientation will be learned so that the offender can begin to develop self-efficacy by being a responsible member of the community.

Job Functions

Job functions are central to the functioning of the therapeutic community. The offenders are taught legitimate job skills that are essential for the community to run well. The job functions create an opportunity for the offenders to participate in pro-social behavior and

thus develop self-efficacy. Offenders are expected to learn the job functions during the first month of treatment. As the offenders show more responsibility in a given job function, they are then assigned to job functions with greater responsibility. The *Therapy Community Structure Board,* provided in the chart below, sets the structure and expectations for offenders. This is followed by a table which highlights job functions by Department/Position, Functional Purpose, and Therapeutic Purpose.

Therapeutic Community Structure Board



Job Functions by Functional and Therapeutic Purpose		
Job Function	**Functional Purpose**	**Therapeutic Purpose**
Coordination Department ▪ Senior Coordinator ▪ Coordinators The Coordinator is one of the highest positions that can be obtained by a participant. Coordinators supervise all community functions. The Community Mentor is a former Senior Coordinator in the Re-entry Phase who supports the new Senior Coordinator.	Responsible for the coordination of all scheduled program activities. The Coordinator must communicate and work closely with program staff. The Coordinator submits weekly reports from all departments to the staff and collaborates with staff and institutional personnel to promote the health, safety, morale, and behavioral growth of all participants.	Coordinator positions enhance: ▪ Appropriate use of authority ▪ Accountability ▪ Supervisory abilities ▪ Organizational abilities ▪ Confidence ▪ Delegation ▪ Speaking/Communication ▪ Effective interactions with program and institutional staff
Unit Clerk	Responsible for the cleaning and maintenance of all offices. The Unit Clerk maintains all Structure Boards, serves refreshments to staff and guests, and organizes the information compiled by Scribes.	Participants may be assigned to the position of Unit Clerk to facilitate time management abilities; organizational, communication, and supervisory skills; and following directions. Attention to detail, management of stress, and acceptance of authority are all skills promoted by this positions.
Service Crew: ▪ Department Head ▪ Ram Rod ▪ Crew Members Ram Rod ensures work is completed and reports directly to the Department Head.	Responsible for cleaning hallways and community areas daily; taking out trash/cleaning garbage cans daily; and cleaning floors, corners, bathrooms, lounges, woodwork, windows, doors, etc.	The purpose of this department is to teach residents to work together cohesively and with responsibility, and to follow given directions and instructions. Residents may be assigned to the Service Crew to promote responsibility, teamwork, accountability, and acceptance of authority and humility.
Scribe: ▪ Department Head ▪ Scribes	Responsible for documenting all program operations and accurately recording all activities and incidents that take place in the therapeutic community.	The position of Scribe fosters attention to detail as well as the need for accuracy, accountability, and responsibility. The position affords the opportunity to learn all the job functions in the therapeutic community and is a stepping-stone to a more responsible position.

Job Functions by Functional and Therapeutic Purpose		
Job Function	**Functional Purpose**	**Therapeutic Purpose**
Logician: ▪ Department Head ▪ Logicians The Department Head is one of the top positions and reports to the Senior Coordinator.	Responsible for collecting Encounter Slips the day before Encounter Group. Logicians are responsible for recording the attendance of all residents at all functions. This department provides a caring and humanistic "go-between" for residents and the Department Heads and to see that Encounter Group Slips are honored and dealt with appropriately.	Residents are assigned to the Logician Department to promote compassion, listening skills, and empathy. The ability to provide assistance in a supportive, direct, and fair manner is fostered along with honesty and honor; attention to detail; and attention to fellow participants.
Media, Education & Recreation ▪ Department Head ▪ Media Crew ▪ Education Crew ▪ Recreation Crew	Media: Responsible for compiling information from magazines, periodicals, newspapers, and other written material pertaining to rehabilitation and treatment. Education: Responsible for coordinating G.E.D., vocational training, and other specialized educational services; and facilitates all seminars. Recreation: Responsible for implementing approved recreational activities for the house.	Assignment to the Media, Education & Recreation Department facilitates creativity, time management skills, problem-solving skills, and organizational abilities. Communication skills and the ability to follow directions are enhanced through participation in this department.
Laundry: ▪ Department Head ▪ Laundry crew	Responsible for the scheduled washing and drying of the house laundry.	The Laundry Department allows participants to practice organizational and time management skills and to have the opportunity to work with Institutional staff.

Job Functions by Functional and Therapeutic Purpose		
Job Function	**Functional Purpose**	**Therapeutic Purpose**
Orientation: ▪ Department Head ▪ Orientors	Responsible for providing an orientation to the community for all new participants. Orientors help new members learn about the program, the structure and the hierarchy of the community, and ensure that each individual is fully prepared to pass the Orientation Test at the completion of the phase.	Assignment to the Orientation Department facilitates listening, communication, teaching, and parenting skills. Participants may be assigned to foster responsibility, their ability to assess needs, and to design and implement plans.
Expediters: ▪ Department Head ▪ Senior Expediters ▪ Expediters The Department Head carries the title of Chief Expediter. This position is responsible for ensuring that the chain of command is utilized properly and the Department Heads are kept advised of all information to be distributed each day.	Responsible for investigating and keeping records of incidents in the community; setting the tone and motivating the community; directing community members to various community functions/groups; and keeping the community informed of any activities.	Expediter are role models for the community and serve as the "eyes and ears" of the program by constantly monitoring and observing the membership. This is a position of trust that sets the model for the rest of the community. Residents may be assigned as an Expediter to promote self-assurance, following directions, and delegation skills. Awareness of one's environment and the behaviors of others is essential to this position, as is the ability to give clear directions to both large and small groups of participants.

The successful implementation and performance of these job functions is critical to the therapeutic community. Participants are responsible for teaching these job functions to each other. As they move higher in the structure, they have increased responsibility to see that these job functions are done well. Through this process, inmates begin to develop positive self concepts (provided they are doing their assignments in a pro-social fashion).

Interactive Journaling

MHM will utilize interactive journaling (developed by the Change Companies) as a central means to present information to those involved in the treatment process. This structured journaling experience provides a venue in which thoughts and feelings can be written about in an organized fashion. The behavior of writing can be seen as the first step of taking on a specific target of change. Concepts from cognitive behavior restructuring (rational thinking), motivational interviewing, and the *Phases of Change* are utilized in the construction of interactive journals. Interactive journaling can create an immediate hook to engage the offender through its focus on the individuals writing about themselves and their unique experiences. There are no "right" or "wrong" answers; but rather, the goal is to get

the offender to begin processing information about a given targeted behavior. It engages offenders by posing questions that go to "personal heat" areas while inviting authentic participation.

The interactive journals are designed to provide small amounts of core information with a consistent tie of "*what does that mean to the offender*?" Graphics are utilized on every page as well as the rule of thirds: White Space/Graphic + Key Content + Questions. Three colors are utilized on each page, which have shown to facilitate engagement and retention; and the use of 70-pound paper results in material that holds up over time and an increased likelihood that end users will refer back to their interactive journals. The content for the women in treatment is similar, but the illustrations are gender-specific.

Each of the interactive journals proposed has a facilitator guide (including a recommended reading list and written instructions) to help achieve the highest level of offender participation. For an example, see **Attachment Q**, *Facilitator Guide for Criminal Thinking*. Ten different exercises are described to facilitate offender's processing of the information. Notes in the margin of the guide provide cues to the facilitator on what point should be stressed on each particular page, as well as recommended exercises.

B.1. TARGET POPULATION

Prison Programs

a. On any given day within DDOC's institutions, hundreds of offenders, with 12 - 30 months left on their sentence, need the level of treatment offered by the different therapeutic community programs. The target population consists of offenders who have a serious history of substance abuse and substance abuse related crimes. They are individuals who typically do not gain long-term benefits from less intensive treatment programs. The programs are not intended for seriously mentally ill offenders, or offenders with serious medical conditions.

MHM understands the target population for the substance abuse program which includes inmates on Level III, Level IV, and Level V supervision; and the available beds as demonstrated in the table below.

SUBSTANCE ABUSE BED CAPACITY	
PROGRAM	**BEDS**
KEY PROGRAM	
Key Program North	200 Beds
Key South	120 Beds
Key Village	96 Beds

SUBSTANCE ABUSE BED CAPACITY	
PROGRAM	**BEDS**
CREST PROGRAM	
Women's Treatment Center	88 Beds
Plummer Community Correctional Center	128 Beds
Sussex Community Correctional Center	100 Beds
Morris Community Correctional Center	144 Beds
Aftercare	300 Treatment Slots
6 FOR 1 PROGRAM	
Howard Young	80 Beds
BOOT CAMP	
Male (SCI)	90 Beds
Female (SCI)	10 Beds
YCOP	
Howard Young	40 Beds

To ensure beds are filled to capacity, we recommend that MHM mental health staff performing intake screenings on offenders referred by the medical vendor conduct a simple drug and alcohol screen (UNCOPE) to identify potential candidates for drug treatment. For sentenced offenders, the lengths of their sentences will be used to determine if they are eligible as potential candidates for the Key program. The recommended admission criterion for the Key Program is as follows:

- Within 18 months of release to Level IV Supervision
- Assessed as having a history of Drug and/or Alcohol Abuse
- No outstanding Detainers
- No history of violent offenses

Offenders who have been diagnosed with mental illness but are able to maintain a high level of functioning while on prescribed medication will be assessed individually and, if appropriate, accepted into treatment. These offenders will be monitored both by MHM program staff as well as MHM mental health clinicians. It is understood that some offenders may be ordered to the program by the Court, and these cases will be reviewed with the DDOC.

Community Correction Programs

b. DDOC is committed to increasing the success of offenders who are transitioning from prisons to the community. Some offenders who are anticipated to be eligible for release in less than 180 days are provided transitional services to facilitate reentry into the community. The Vendor must coordinate the transition of offenders who complete the Key Programs to community correction programs.

MHM acknowledges, accepts, and will comply with the above requirements.

There will be weekly case management meetings in the Level V (Key) programs to review inmates' movement and treatment. These meetings will be attended by the Program Manager, Clinical Supervisor, and assigned counselors. Members from the State's Classification Committee will be invited to join. As a part of these meetings, MHM staff will interface with the Department as the DDOC determines who is eligible to move to Level IV supervision. We will adjust the inmate's individual treatment plan accordingly to aid in the transition from the Key Programs to the community correction programs.

Aftercare

c. DDOC believes that released offenders with strong support and accountability systems are less likely to re-offend. Furthermore, it is expected that aftercare will lower recidivism and make Delaware a safer place to live. Aftercare is the third and last step in Delaware's substance abuse continuum of care. Offenders who complete one of the Key programs and go on to complete a community correction program (CREST) are expected to participate in a 6 months aftercare program. The contractor will be required to work in collaboration with probation/parole officers and other organizations as needed toward keeping released offenders away from returning to prison.

MHM acknowledges, accepts, and will comply with the above requirements. Participation in Aftercare is a required part of substance abuse treatment, and research has shown that offenders participating in the full continuum of treatment (usually lasting 24 months) will recidivate less than those who do not.

The Aftercare Programs will run from the four CREST sites in the State. We will ensure a strong interface with probation/parole for those clients who are under supervision. As agreed upon by the DDOC, some aftercare programming may be provided at probation/parole locations. Aftercare treatment in the community-based settings completes the continuum of care model in the efforts to facilitate the offenders' habilitation efforts with successful crime and drug-free living in the community.

Assistant Program Managers (referred to as Program Directors in the RFP) for these Level IV and Level V programs will be required to develop working relationships with the transition resources and organizations listed in *Section B.8,* below. As mentioned in *Section B.6,* we will recruit those individuals currently working in the program who wish to remain in their positions and are in good standing with the DDOC; and will further the

existing relationships they have developed with local community organizations.

For offenders who have co-occurring disorders, MHM staff will assist in connecting them with community centers as a part of their discharge plan.

6 for 1 Program

We understand that the 6 for 1 Program is a 30-45 day program for detainees who are awaiting an appearance before the Court. The focus of this program will be on substance abuse education and cognitive restructuring. There will be components to the program that are similar to the therapeutic community (such as how the daily program is scheduled and having detainees be responsible for their living areas).

Young Criminal Offender Program (YCOP)

The Young Criminal Offender Program is designed to work with between 16 and 18 years of age who have been reprimanded to Superior Court because of the seriousness of their charges and/or their non-responsiveness to the Family Court System. Some offenders in this program will likely be or have been convicted of serious felonies which will result in long-term sentences.

Independent of each offender's particular circumstances, our goal will be to facilitate the young offenders in assessing their choices and motivating them to live in a responsible manner either in the correctional system or back in the community. It is our belief that offenders must be held accountable for the choices they have made. Therefore, the structure of a therapeutic community treatment model (which is based on social learning theory) provides an opportunity for offenders to be held accountable for their behaviors on a day-to-day basis as they learn how their past choices have resulted in incarceration and how they might make different choices resulting in positive outcomes.

According to social learning theory, aggressive attitudes and behaviors are acquired and maintained primarily through three primary sources: observational learning, direct experience, and self-regulative influences (Bandura, 1953, 1973.) Fortunately, non-aggressive, pro-social behaviors are learned and reinforced in the same way. By teaching offenders pro-social behaviors and having them repeatedly enact these behaviors, pro-social behaviors begin to replace anti-social behaviors. The structure of the therapeutic community provides numerous opportunities for offenders to learn pro-social behaviors. Social learning theory is applied through modeling, role-playing, social skills training, coaching, feedback, and self-monitoring – all of which are utilized to help the client develop a pro-social repertoire (Wexler et. al., 1985).

Boot Camp Program at Sussex Correctional Institution

The design of this program is to complement the Boot Camp Staff by providing Substance Abuse Education and Cognitive Restructuring. Given the structured nature of the Boot Camp setting, cadets will have the opportunity of learning pro-social repertoires in a similar fashion as those participating in the structured therapeutic treatment setting.

B.2. Referral Process

The Key programs will serve offenders who have been identified as candidates for the programs, from many of DDOC's institutions across the state. The DDOC classification staff will refer the candidates to the Key programs based on information provided during the admission interviews and based on sentencing orders. Offenders will be referred to the Key programs so that their community correction eligibility coincides with their estimated program completion date. Most of the offenders who successfully complete the Key program will be rewarded for their successful program participation with opportunities to transition into community correction programs (CREST Programs).

MHM acknowledges, accepts, and will comply with the above requirements.

MHM staff will interface with classification staff at all DDOC facilities to help identify potential offenders for the Key and CREST Programs. During admissions interviews, the DDOC classification staff will identify potential candidates for drug treatment services either by history and/or court orders. Offenders will be referred to the Key programs so that their community correction eligibility coincides with their estimated program completion date. Most of the offenders who successfully complete the Key programs will then transition to a CREST Program.

B.3. Recruitment

Although the DDOC's classification staff will refer candidates for program participation based on their substance abuse history and/or sentencing orders, recruiting offenders to participate in Therapeutic Community ("TC") programs is the sole responsibility of the vendor. The Vendor must maintain a list of eligible candidates and coordinate with DDOC to ensure that eligible candidates are placed in the appropriate treatment program based on clinical indicators.

The Vendor must review new admissions, interview offenders, examine sentencing orders, and develop a list of potential candidates for the programs. The vendor must communicate with classification and security staff to coordinate transferring offenders who meet the admission criteria into the programs.

MHM acknowledges, accepts, and will comply with the above requirements.

While DDOC staff will be referring offenders to drug treatment, MHM will actively recruit in all DDOC facilities to promote the substance abuse program. MHM staff will coordinate with administrations of the various DDOC facilities so that presentations can be made to offenders about the potential benefits of participating in treatment. MHM recommends that offenders who are currently in treatment also be utilized to lead presentations (under supervision) in Level V facilities to share the benefits of being in treatment. A referral tracking system will be developed so that those offenders referred and those expressing interest can be processed in a systematic manner. This system will ensure

that offenders are interviewed and screened in a timely fashion.

MHM's mental health staff will screen offenders referred from the medical staff for drug and alcohol during intake screenings using the UNCOPE assessment tool. Referrals will be made to our Case Managers. We will also participate in the weekly classification meetings led by the Institutional Classification Committee (ICC). Interviews will be conducted by either the Case Managers or assigned counselor from one of the programs. They will be used to determine the extent of the drug and alcohol difficulties as well as the inmate's readiness/willingness for treatment.

We will maintain a running log of all individuals who have been identified as being sentenced to drug treatment. This log will include lengths of stay in order to determine priority for admission to the program. MHM will also keep a waiting list of potential candidates based on referral.

Staff will be trained on how to review the case file to determine whether the Court has ordered any specific type of drug treatment services through sentencing orders.

B.4. Physical Location of the TC Programs

i. **Key North Program at Howard R. Young Correctional Institution in Wilmington, DE**
ii. **Key South Program at Sussex Correctional Institution in Georgetown, DE**
iii. **Key Village Program at Baylor Women Correctional Institution in New Castle, DE**
iv. **CREST North Program at the Plummer Community Correctional Center in Wilmington, DE**
v. **CREST Central Program at the Morris Community Correctional Center in Dover, DE**
vi. **CREST South Program at Sussex Community Correctional Center in Georgetown, DE**
vii. **CREST North Program for Women at Women Work Release Treatment Center in New Castle, DE**
viii. **6 for 1 Program at Howard R. Young Correctional Institution in Wilmington, DE**
ix. **Young Criminal Offender Program at Howard R. Young Correctional Institution in Wilmington, DE**
x. **Boot Camp Program at Sussex Correctional Institution in Georgetown, DE**
xi. **Aftercare Program, Statewide**

MHM acknowledges the physical location of the programs as identified above.

B.5. Collaboration between Treatment Vendor and Security Staff

While security is the primary concern of any Delaware correctional facility, a healthy and effective treatment program enhances security. DDOC is committed to providing

treatment opportunities to offenders in order to enhance their ability to live free from negative consequences of addiction.

New treatment staff will receive training on basic security measures from the DDOC staff. Vendor's staff will keep the DDOC staff apprised of all treatment activities. An open line of communication between correctional and treatment staff is imperative. Security staff will be accessible to the treatment staff to discuss planning, schedules, special program events, the movement of prisoners to and out of the treatment programs, the recruitment of program participants, and issues pertaining to security.

MHM acknowledges, accepts, and will comply with the above requirements.

It is understood that security is a primary goal of any correctional setting and a well designed treatment program can facilitate the goal of security. The only way that treatment programs can be effective in the correctional setting is if all vested parties are in agreement with the mission of the program and involved in the process. It is understood that MHM treatment staff will receive training on basic security measures from the DDOC staff. In turn, we will offer training for correctional officers assigned to any of the treatment facilities to include the mission statement and objectives of the program as well as our methods of approach. For further information regarding substance abuse training, please refer to *Section D.iv, Training,* below.

MHM staff will keep DDOC staff apprised of all treatment activities and maintain an open line of communication through daily briefing and debriefing between shifts with treatment and security staff. MHM staff will also work with security staff to discuss planning, schedules, special program events, the movement of prisoners to and out of the treatment programs, the recruitment of program participants, and other issues pertaining to security.

Either the Program Manager or Clinical Supervisor will be on-call to respond to emergency situations. On-call number(s) will be conspicuously posted on site for DDOC staff.

We recognize that the monthly MAC meeting will be the standard forum. However, we expect to maintain close contact with the medical vendor through daily interaction and informal communication. Should there be an immediate medical need, one of our management members will contact the medical vendor, advise them of the situation, and follow-up on any ongoing issues.

For further information on collaboration, please see *Tab 4, Section X, C.16* and *Tab 5, Section IV, e.*

B.6. Treatment Staff Description and Qualification

The Vendor must have experience working with offenders in the criminal justice system. The Vendor should have experience working with offenders in the criminal justice system in a residential treatment setting, although not all positions must be

filled by individuals who have experience in a residential treatment setting.

Program directors must be Certified Alcohol & Drug Counselors (CADC). If a candidate for a program director is not yet certified, the treatment Vendor must submit in writing to the DDOC Substance Abuse Treatment Administrator the justification for hiring or proposing the individual for the job. The treatment Vendor must also submit the plan and schedule, agreed upon by the proposed candidate for program director, for obtaining certification. The timeframe to obtain certification should not exceed one year. Written approval must be obtained from the DDOC Substance Abuse Treatment Administrator prior to hiring individuals without proper certification as clinical supervisors or program directors.

All substance abuse counselors who are working under the resulting contract must be skilled in the field of substance abuse, especially in the therapeutic community model and it is preferred that counselors are knowledgeable of the criminal personalities.

In addition:

- **The Vendor must describe in detail how they propose to staff the treatment programs.**
- **Position titles and descriptions (including qualifications and experience required for each position) must be included.**
- **A plan for how the staff would interact, collaborate, and partner with the DDOC staff and other Vendors must also be described.**
- **The Vendor must describe work schedule proposed for each position. Include information such as whether any position is working weekends or evenings.**
- **All staff must be approved by the DDOC Substance Abuse Treatment Administrator.**

MHM acknowledges, accepts, and will comply with the above requirements. MHM has extensive experience working in corrections as evidenced in *Tab 2, Section III, B.1.*

Oversight for our mental health and substance abuse programs will be provided by Robert M. Hooper, PhD (see *Tab 2, Section III, B.1).* Dr. Hooper is well known for his work in substance abuse treatment within the criminal justice field beginning in Delaware in 1987, when he worked with staff from DDOC in the creation and ongoing development of the Key Program. Subsequently, he worked with DDOC staff and the Center for Drug and Alcohol Studies, University of Delaware in the development of the CREST Program and Aftercare. His background in the field of substance abuse treatment in the criminal justice setting and in the development of the programs in Delaware will be utilized in guiding MHM.

Upon contract award, we will interview all current staff to recruit those individuals who wish to remain in their positions and are in good standing with the DDOC. We have identified a highly qualified Program Manager who is a Certified Alcohol & Drug Counselor, but the candidate has requested not to submit their information until contract

award. With Dr. Hooper's extensive experience in this field, it is judged that staff can be recruited once it is determined if current managers at the program level need to be replaced.

MHM Assistant Program Managers will be Certified Alcohol and Drug Counselors (CADC). If an Assistant Program Manager Candidate is not yet certified, MHM will submit in writing to the DDOC Substance Abuse Treatment Administrator our justification for hiring or proposing the individual for the job. MHM will submit the plan and schedule for obtaining certification which will be agreed upon by the proposed candidate for Assistant Program Manager. This timeframe will not exceed one year. All substance abuse counselors will be skilled in the field of substance abuse and a special effort will be made to retain counselors with experience working in a therapeutic community. Training will be provided on the dynamics of a therapeutic community as well as working with criminal personalities.

Although we have provided an initial staffing plan (see *Section G, Work Schedule),* we will develop a final staffing schedule with the DDOC. We understand that all staff must be approved by the DDOC Substance Abuse Treatment Administrator. Position titles and descriptions (including qualifications and experience required for each position) are included in **Attachment L** along with an organizational chart for each of the programs. For information on collaboration, please refer to the preceding section.

B.7. TREATMENT VENDOR WORK SHIFT

The Vendor's treatment staff will work shifts providing program coverage 7 days a week, from 7:00 am until 8:00 pm, if possible and appropriate. The DDOC staff will maintain a presence 24 hours a day, and will debrief with treatment staff each morning. The counselors' hours will be established by the treatment Vendor in coordination with the DDOC staff. It is required to have staggered shifts for some weekend and evening coverage. Vendors are encourages to offer ideas in their proposals for staffing patterns and program coverage.

MHM acknowledges, accepts, and will comply with the above requirements.

As mentioned previously, MHM staff will provide daily briefing and debriefing between shifts with treatment and security staff. Hours will be established in coordination with the DDOC staff.

MHM will provide staggered shifts to ensure day and evening coverage when possible and appropriate as evidenced in *Section G, Work Schedule*. This includes weekend nights with the exception of the 6 for 1 Program and YCOP Program which will only have day coverage on weekends; and the Boot Camp Program which does not require coverage on the weekends. On-call services, described earlier, will be provided should an emergency should arise.

B.8. Transition Resources

The Vendor must be familiar with state approved and funded community substance abuse programs. The Vendor will develop referrals for safe housing, medical assistance, education, vocational training, and other needs. Because transition planning is crucial to the success of the DDOC substance abuse program, the Vendor must describe its strategy in details.

MHM acknowledges, accepts, and will comply with the above requirements.

MHM treatment staff are committed to establishing and maintaining professional relations with civic groups, agencies, government entities, other professionals, and the community-at-large in order to ensure appropriate referrals; identify service gaps; expand community resources; and help address unmet needs. The MHM Program Manager, along with staff working in the CREST and Aftercare Programs, will meet with the agencies listed below. It is anticipated that a number of staff who are currently working in substance abuse services will be retained by MHM, hence some relationships may already be developed. The following list identifies providers who currently provide services:

- TASC/New Castle, Kent, and Sussex County
- Connections CSP Inc.
- Sojourner's (Wilmington)
- Brandywine Counseling

Housing Resources:

- Friendship House (Men Wilmington)
- Epiphany House (Women Children)
- Gateway House (Men)
- Limen House (Men)
- Limen House (Female)
- Sunday Breakfast Mission/(Men)
- Salvation Army (Wilmington, Kent County, Sussex County)
- Sojourner's (Wilmington)
- The Way Home Program
- Men's Oxford House, (Lewes and Georgetown)
- Women's Oxford House (Georgetown)

Employment and Education

- James Grove Adult Education (GED)
- Del Tech (Work Force Training Programs)
- Vocational Rehabilitation (New Castle, Kent, and Sussex Counties)
- Department of Labor (Kent and Sussex Counties)

HIV Services

- AIDS Delaware

Social Services

- DE Health and Social Services
- Division of Public Health

Other Services

- DE Counseling on Gambling
- DE Center for Justice
- Prison Military

B.9. URINALYSIS TESTING

Random urinalysis (UA) of program participants may be conducted at any time. DDOC is responsible for the UA component of the substance abuse treatment programs. If an offender has a dirty UA, sanctions will be imposed. It will be possible for an offender who has been discharged from the program for an infraction to earn his way back into the program. Such case management decisions will be made on a case-by case basis by DDOC.

It is understood that random urinalysis (UA) can be conducted of program participants at any time. The DDOC is responsible for the UA component of the substance abuse treatment programs. If an offender has a positive UA, sanctions will be imposed. It will be possible for an offender who has been discharged from the program for an infraction to earn his/her way back into the program. MHM would like to consult with the DDOC in such situations on a case-by-case basis.

C.1. PROGRAM PHASES

Offenders' length of participation in the programs will depend upon type of the program, individual treatment needs, and time left before release to the community. It should be noted that the average length of the Key Programs is twelve months, the average length of the CREST program is six months, and the average length of Aftercare is six months. The program will be structured in phases incorporating an orientation/education phase, a primary treatment phase, and a transition phase. The Key Programs should consist of the following phases with the approximate time frames:

Treatment Phase	Duration
Phase I	**90 days**
Phase II	**210 days**
Phase III	**60 days**

The time frames listed above may be altered somewhat by the Vendor as long as the clinical reasons for doing so are sound. The phases listed above are basic. A Vendor may build upon the phases in describing their plan for service provisions. The Vendor should describe what objectives need to be obtained by the offender in order to progress from one phase to the next. When describing the phase system the

Vendor should describe how program participants earn increased responsibilities and privileges. Also, the value of peer support for participants in progressing through the phases should be expanded upon.

Phase I provides the participant with an orientation to the TC as well as substance abuse education. It is also the staging ground for treatment. The offenders learn the TC vocabulary and concepts.

Moving into Phase II is an honor, and becoming a member of the TC "family" is earned. Phase II provides the primary care which is the heart of treatment.

Phase III is the transition care segment where offender prepares for moving into his home in the community or into a program within Community Correction. The Vendor works with offenders individually while they are in phase III to assist them in preparing for life outside the institution.

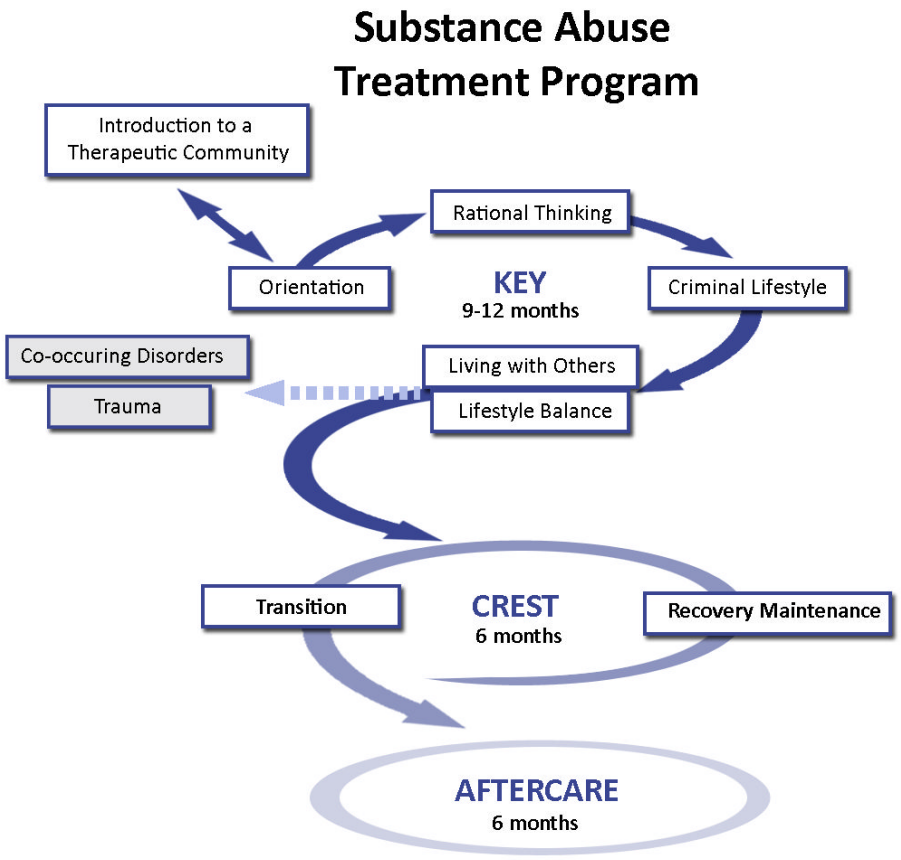
MHM acknowledges, accepts, and will comply with the above requirements.

Below, we provide an overview of each program including our plan for the provision of services; phases; how participants earn increased responsibility and privileges; and the objectives needed in order to progress between phases

Key/CREST/Aftercare Continuum

We understand that the Key Program is designed to be approximately 12-months long with three phases of treatment: *Phase I, Orientation*; *Phase II, Primary Treatment*; and *Phase III, Transition*. The strongest program design for best outcomes is to have offenders commence treatment at Level V (the Key Program) and progress through the CREST and Aftercare Programs. As cited by Inciardi et. al., (1997), clients receiving treatment in two stages (work release and aftercare) and three stages (prison, work release, and aftercare) have significantly lower rates of criminal recidivism and drug relapse. In fact, this research was based on the Delaware Key, CREST, and Aftercare programs.

MHM will ensure strong case management in order to manage offenders through all phases of the continuum. For those offenders directly committed to the CREST Program, there will be intensive programming during the first three to four months of treatment prior to transitioning to work and/or school in the community.



Key Program

Phase I of Treatment: Orientation

For offenders classified to the Key Program there will be two concurrent orientation programs the offenders will participate in: 1) *Orientation* 2) *Introduction to the Therapeutic Community.* This two-phase process will provide offenders with the opportunity to learn how to function within the therapeutic community while being heavily exposed to *consciousness raising* (as discussed previously). The topics covered in the *Orientation* Manual are as follows:

- Looking At Me
- Preparing for Treatment
- Keys for Change
- My Drug Use

During the course of *consciousness raising*, offenders will have the opportunity to accomplish the following:

- Explore the Choices You Have Made
- Look at Your Current Situation
- Understand the Expectation of the Treatment Program
- Recognize Self-Defeating thoughts that are roadblocks to change

- Explore positive attitudes for successful treatment and learn how to do an **Attitude Check**
- Learn Essential skills needed in order to make positive lifestyle changes
- Look at the damaging consequences of one's drug use behavior
- Prepare a **Readiness Statement** as the starting point for lifestyle change

There are two themes utilized throughout the curriculum: **Attitude Check** and **Rational Self- Analysis (RSA)**, discussed in Phase II. The offenders will be taught about the importance of the following attitudes critical to the process of change:

- Gratitude
- Objectivity
- Caring
- Humility
- Open-Mindedness
- Willingness
- Responsibility
- Honesty

In the Orientation Manual, the offender is asked five questions about these attitudes:

1. Select one of the eight attitudes and describe a recent situation in which you found yourself struggling with that attitude.
2. Which attitude were you struggling with?
3. Describe a recent situation in which you demonstrated a positive change in your attitude and behavior.
4. Which attitude were you demonstrating?
5. Describe the benefits you will experience if you continue to work on these positive attitudes.

The Attitude Checks provide the opportunity for c*onsciousness raising*, and help the offender begin to develop self-efficacy when describing a positive episode and the likely outcomes if one continues to demonstrate the positive attitude. Attitude Check Pads will be provided to the Offenders so that during the course of treatment, multiple Attitude Checks can be completed and discussed in both group and individual settings and can serve as a basis for self-reflection. The use of Attitude Checks continues throughout the program. When the offender finishes this *Orientation Journal* he/she must write a **Readiness Statement** which includes the following questions:

1. A description of what drugs you used and how they damaged your life and the lives of those close to you.
2. Your need for the help of your group and this treatment program to change your life.

The content of the Readiness Statement will be shared with the staff and community alike. The statements are to be kept by the offenders so that they can be reviewed on an "as needed" basis.

The second interactive journal in Phase I is *Introduction to the Therapeutic Community* (see **Attachment M**). The offender is given the opportunity to learning the following concepts:

- Understand how to work together to bring about positive change
- Explore the structure and function of a therapeutic community
- Learn the cardinal rules
- Examine your role as a member of the community
- Consider important concepts within the community
- Learn therapeutic community tools.

Orienting offenders to the therapeutic community provides them with an opportunity to learn the expectations of the treatment process as well as become engaged in pro-social behaviors. As the offenders are taught job functions and then begin enacting them, they are involved in pro-social activity for which they are given positive feedback. As their contribution to the community increases, their self-efficacy will begin to grow because of the positive contributions they are making. Hence, learning the job functions (discussed previously) and taking on more and more responsibility is a critical part of the treatment process. Within the structure of the therapeutic community, the offender begins learning more and more about how they have perceived and behaved in the world and how they might change that in a pro-social manner.

In order to move to Phase II treatment the offenders must accomplish the following:

- Know and demonstrate adherence to the cardinal rules
- Define the job functions listed on the structure board
- Be Successfully completing one's assigned job functions
- Know the 8 Attitudes for Change and be able to complete Attitude Checks
- Complete and share one's Readiness Statement

Phase II of Treatment: Primary Treatment

In Phase II of Treatment, *consciousness raising* continues with the goal of moving offenders through the *Phases of Change* to Contemplation and possibly Preparation and Action to change certain targeted behaviors. Three Modules are covered in Phase II:

1. **Rational Thinking**
2. **Criminal Lifestyles**
3. **Living with Others**

Each of these topics is covered in detail in an interactive journal, which includes facilitator instructions for the classroom aspect of treatment. Work that is completed in the classroom setting is then followed-up with assignments that are expected to be completed in the living unit and/or become a focus for group and individual counseling sessions.

Rational Thinking: In this interactive journal (see **Attachment N**) the offender is provided the opportunity to

- Recognize how your thoughts control your feelings and behavior
- Identify common errors in thinking that pop up in your daily self-talk
- Explore tools you can use to improve your thinking style
- Learn and practice a process called Rational Self-Analysis (RSA) through which you make your awareness about events more accurate and make your thoughts more rational
- Understand how habits are formed and the difference between education and re-education
- Learn how to handle the uncomfortable feeling that occurs when you try to change a habit

The major thrust of the cognitive restructuring utilized in this program is the teaching of RSA. MHM will introduce this concept early in the program so that offenders can develop the skill to understand how they think and feel about the world as well as ways to develop different perceptions. RSA teaches offenders how to examine their beliefs, attitudes, and any thinking errors in order to facilitate the development of pro-social beliefs and attitudes. The first step of this process is learning one's ABCs:

A = Activating Event: The event or situation as the individual saw or experienced it.
B = Beliefs: One's thoughts, beliefs, and attitudes regarding the Activating Event.
C = Consequences: The outcome including how one felt and acted.

Offenders will be directed through numerous exercises to identify Activating Events and what their Beliefs were and the resulting Consequences. As with Attitude Checks, offenders are provided with tear-off sheets so that numerous RSAs can be completed and utilized for Group and Individual Sessions. As offenders progress in *Rational Thinking,* they will be better prepared to commence the next interactive journal, *Criminal Lifestyles*. With the application of RSA, offenders will be more capable of identifying faulty thinking and attitudes and thus impact outcomes, or consequences, in a more positive fashion.

The second sequence in *Rational Thinking* will focus on identifying the thinking errors listed below:

- Absolutes
- I Can't
- Rhetorical Questions
- Awfulizing
- Statement of Fact
- Should
- Have To, Need To, Must
- Loaded Words
- Blaming
- He, She, It Statements

Each of these thinking errors is explored in detail and then numerous exercises, including Attitude Checks and RSAs, are completed to help offenders determine how particular thinking errors apply to self and what a more rational way of thinking would be. The next section of the interactive journal reviews the "Five Rules for Rational Thinking":

1. Are your thoughts based on objective reality/facts?
2. Are your thoughts helping you protect your life and health?
3. Are your thoughts helping you achieve your short-and long-term goals?
4. Are your thoughts helping to keep you out of conflict with others?
5. Are your thoughts leading you to feel the way you want to feel without the use of alcohol and other drugs?

With direction from MHM staff, offenders will work through a set of exercises that include doing self-application. Upon competing *Rational Thinking,* the offenders will begin the interactive journal, *Criminal Lifestyles* once the following objectives are met:

- Know the steps for RSA and be able to complete an RSA as directed.
- Be able to list and apply the 10 Thinking Errors
- Be able to list and apply the 5 Rules for Rationale Thinking

Criminal Lifestyles: The goals with this interactive journal are as follows:

- Examine the costs and payoffs of your criminal behavior
- Explore the 3 C's-Conditions, Cognitions, and Choices; and learn how they apply to you
- Understand how criminal thinking errors support a criminal lifestyle
- Apply RSA to your criminal thinking
- Learn about the harmful attitudes of manipulation and grandiosity
- Explore the ripple effect of criminal behavior on others
- Examine your history of social rule-breaking
- Develop your "Statement of Commitment."

Once again, *consciousness raising* is utilized in an attempt to get the offender to assess the dynamics of criminal thinking and what the application is to self. Content from the previous interactive journal is built upon with the application of RSA toward criminal thinking dynamics. To accomplish the goals listed above four major topics are addressed:

1. Criminal Thinking and Behavior
2. Criminal Thinking Errors
3. Applying Rational Self Analysis
4. Foundation for Change

As a first exercise, numerous examples of payoffs associated with criminal behavior will be given to the offender with direction to add additional payoffs. Despite the payoffs, the end result is prison. This graphic example encourages the offender to think and visualize where life will lead with one's current perceptions of the world. The offender has

numerous exercises to do on identifying Criminal Thinking Patterns, concluding with an application to self to determine which Criminal Thinking Patterns apply.

The next section of the interactive journal will teach offenders how to do an RSA on Criminal Thinking. In these exercises, the goal is to (at a minimum) move the offender to Contemplation in terms of how one's criminal thinking may not be compatible with desired outcomes. The offender is then moved toward assessing what impact their criminal behavior has had on others as well as introducing the notion of *Empathy*. Prior to moving to the next interactive journal the offender must complete the following objectives:

- Describe the costs and payoffs of one's criminal actions
- Describe and apply the 3 C's: Conditions, Cognitions, and Choices
- Describe the 8 Criminal Thinking Patterns
- Identify and Describe your Criminal Thinking Patterns
- Apply an RSA to one's Criminal Thinking Patterns
- Complete and Share "My Statement of Commitment"

In the next interactive journal *Living with Others***,** four major areas are reviewed:

1. Exploring Relationships
2. Effective Communication
3. Anger Management
4. Road Blocks to Positive Attitudes

Being able and willing to live responsibly with others is typically not done well by the incarcerated**.** The *Living with Others* interactive journal focuses on the nature of the relationships the offender has experienced and what might be done differently going forward. The goals of the interactive journal are as follows:

- Explore the components of healthy and unhealthy relationships
- Learn proven ways to communicate effectively with others
- Learn to recognize your personal anger cues and the impact anger has on you
- Explore strategies to help you manage your anger and develop a personalized anger management plan
- Examine three roadblocks to positive attitudes: resentment, self-pity, and grandiosity

As offenders are directed through the material on relationships, numerous Attitude Checks will be completed. Once again, the positive attitudes for change are coupled with the dynamics of relationships, and the offender is pushed to be honest with self and others as he/she explores the history of his/her relationships and what is desired in future functional relationships.

There is a targeted section in *Living with Others* on understanding and managing one's anger. The offenders will be taught to recognize their anger cues and how to manage that emotion through rational thinking. Offenders are directed to review episodes when they

became angry both in the community and while in incarceration and what the consequence was. Five different strategies are reviewed and practiced to manage one's anger:

1. Examining your thinking
2. Seeking compromise
3. Taking a time out
4. Checking your attitude
5. Keeping your options open

Based on these strategies, the offenders are directed to identify their "hot spots" and then develop a management plan for each. Once again, an Attitude Check is completed at the end of the segment in relationship to anger management.

In the last section, *Living with Others***,** roadblocks to positive attitudes are explored.

- Resentment
- Self-Pity
- Grandiosity

Offenders complete applications on how each of these potential roadblocks can be perceived in an irrational way or as a rational challenge. For example, when dealing with letting go of resentments, the implications of holding onto resentments are reviewed as well as what could be healthy about letting go of resentments.

For offenders to move to Phase III of treatment, the following objectives must be met upon completion of *Living with Others*:

- Define the four positive attitudes for healthy relationships.
- Describe the three negative relationship patterns
- Describe and apply four styles of communication
- Describe and apply five strategies for managing one's anger
- Write and share "My Anger Plan"
- Describe and apply three road blocks to positive attitudes

It should be noted that offenders must follow the rules and routines of the therapeutic community during the entire course of treatment including performing their assigned job functions and becoming a role model for the treatment community. In Phase III, offenders will be heavily involved in their job functions and will have additional responsibility; thus, the amount of program content will not be as great as in Phase I and Phase II.

Phase III of Treatment: Transition

Lifestyle Balance is explored in Phase III. Often offenders have learned very little (or nothing) about balancing one's lifestyle. Life in the so-called "fast lane" goes from

drugging to unhealthy relationships to avoiding arrest. One's lifestyle is often a complete illustration of irresponsibility. Thus, the last focus in Level V treatment is *Lifestyle Balance* to help prepare the offenders for the Level IV CREST Programs during which *Recovery Maintenance* and *Transition* will be the central focus. There are six areas of focus in *Lifestyle Balance*:

1. Reviewing the Concept of Balance
2. Physical Health Spoke
3. Emotional Health Spoke
4. Healthy Relationships
5. Examining Job Satisfaction
6. Community Involvement Spoke

While working through these six different areas offenders will have the opportunity to achieve the following:

- Evaluate whether or not their lives are in balance and learn how to make positive adjustments in important areas
- Learn the elements of physical health
- Evaluate their emotional well-being
- Examine their relationships
- Look at the role job satisfaction plays in a balanced lifestyle
- Learn about the importance of positive community involvement

Often in a correctional treatment setting, the focus is strictly on drug and alcohol treatment combined with criminal thinking. It can be argued that residential treatment in a prison is the "easy part" of the hard road to recovery because one's time is structured and one's setting is safe. Learning how to live on life's terms is a much larger challenge. MHM staff will present information on balanced lifestyle concepts to help offenders make successful adjustments when transitioning back into the community. Offenders are directed to describe what "in balance" and "out of balance" means to them and then to describe the main reasons they are in or out of balance. To complete this interactive journal the offenders must:

- Describe the five spokes of a balanced lifestyle
- Identify the one spoke likely to break
- Explain the reasons the spoke was selected
- Explain skills to be developed so the spoke is less likely to break

Completion of all curriculum, consistently following the rules of the therapeutic community, and time are a number of factors considered for transition to the CREST program. MHM will provide written recommendations to the Institution Release Classification Board regarding transition.

CREST Programs

The CREST Programs will have two different populations, those offenders who are transitioning from a Key Program and those individuals who have been directly committed to Level IV treatment by the Court. Those offenders who are directly committed by the Court will have a much more structured program for three to four months so they can move through material that those transitioning from the Key Programs have already covered. The graduates from the Key Programs will focus on *Recovery Maintenance* and *Transition* and will serve as role models for the newer CREST members. Graduates from Key will also begin conducting job searches and/or exploring educational opportunities.

It is understood that a significant effort in the treatment continuum is *Recovery Maintenance* and *Transition*. The following topics are examined:

- Review of Recovery Maintenance
- Stage 1: Damaging Attitudes
- Stage 2: Lifestyle Imbalance
- Stage 3: Increased Discomfort/Conflict
- Stage 4: Urges and Cravings
- Stage 5: High Risk Situations
- Stage 6: Single Use
- Recovery Maintenance Plan

New thinking processes are introduced to help offenders manage difficult challenges. Offenders who take advantage of the program will accomplish the following:

- Complete a review of one's strengths
- Learn what recovery maintenance is
- Learn strategies to return to recovery after understanding damaging attitudes, lifestyle imbalance, increased discomfort/conflict, urges and cravings, high-risk situations, single use, and continued use
- Identify a possible relapse scenario
- Develop a recovery maintenance plan

Each of the stages identified above can pose a threat to one's recovery. Therefore, offenders will work with MHM staff to develop a Recovery Maintenance Plan including exit strategies for these situations. These plans are developed in conjunction with ongoing Attitude Checks as well as RSAs. To complete this segment successfully, the offender must be able to do the following:

- Describe the four steps to recovery maintenance
- Define the six stages of relapse
- Define exit strategies for each of the six stages of relapse

The *Transition* module covers the following topics:

- Evaluating Expectations
- Key Transition Issues
- Statement of Change

In order to address these topics, the following goals need to be met:

- Evaluating whether one's future expectations are realistic
- Examining three Key transition issues one will encounter including working with authority figures, handling social pressure, re-entry, and relationships
- Reviewing the skills one has learned throughout the program and how one can use these skills during one's transition
- Developing a Personal Statement of Change

The focus of *Transition* is on the application of data. Therefore, the offender must demonstrate an ability to apply concepts presented in the program to situations likely to be encountered upon release to the community. For example, MHM staff will work with the offender to evaluate how realistic his/her plans are once released. The offender will be directed to perform an Attitude Check on "open-mindedness" and "humility" in relationship to working with authority figures such as one's employer and probation/parole officer. RSAs are completed on likely situations that will be encountered in the community. Once these exercises are completed and discussed, then the offender will complete a Personal Statement of Change in which the following items are addressed:

1. This is what I was like before entering the Program (Consider how you thought, what your attitude was like, and how your harmful behaviors affected you and others).
2. This is what I have learned since entering the Program (Review the attitudes and thinking errors that have given you the most trouble).
3. Knowing myself as I do, what do I need to do to get where I want to go? What pitfalls are there for me to watch out for?
4. What would I like to say to an inmate who is trying to decide if he wants to sign up for the program?
5. After presenting your Personal Statement of Change in front of the group, complete the following statement, "This is the feedback I received from the group on My Personal Statement of Change."

Based on the feedback received from the group, the Offender is instructed to rewrite responses to questions one through four which are then reviewed with staff. The extensive work done in the last journal provides excellent data on what the offender has or has not incorporated in his/hers effort to change. For completing of this segment the offender must accomplish the following:

- Describe the five Key transition issues

- Write and share his/ her Personal Statement of Change

Co-occurring Disorders
Offenders with an Axis I diagnosis who are stable (with or without medication), will be accepted into the Key and/or CREST Programs. MHM substance abuse staff will interface with our mental health staff to coordinate the care for these offenders. When agreed upon by mental health staff, the Key and/or CREST Staff can provide these offenders with an interactive journal, *Managing Co-occurring Disorders, An Integrated Approach*. This Journal is divided into Six Sections:

1. Introduction
2. Looking At Me
3. Dual Diagnosis
4. Roadblocks
5. Positive Attitudes
6. Commit To Change

Within these six sections, the following opportunities are presented to the offender:

- Examine your current problems and the resulting consequences
- Consider the connection between drug use and mental health conditions
- Explore your roadblocks to positive life change
- Learn about positive attitudes for success
- Identify your top three challenges
- Write a Readiness Statement

The substance abuse staff can provide monitoring of the journal assignment in conjunction with the mental health staff. During case management which includes meeting with the offender, progress is monitored on how well the offender is doing with compliance to the treatment plan, including the completion of program assignments as well as medication compliance.

For offenders identified as having suffered a traumatic event(s), there is an interactive journal, *Trauma*, which can be assigned to the appropriate offenders upon approval by mental health staff. The topics covered in this interactive journal are as follows:

- Understanding traumatic experiences
- Recognizing the impact of traumatic experiences
- Identifying psychological disorders
- Resolving difficulties through treatment

The general purpose of this interactive journal is to provide an overall view of what trauma is, how well one has responded to traumatic events, and what needs to occur if professional help is required.

Aftercare

As offenders transition into Aftercare, they will have approved housing in addition to work and/or attending school. Aftercare services will be provided in each county and at the appropriate CREST Program and/or Probation and Parole Office dependent upon the schedule established with the DDOC. When first transitioning to Aftercare, offenders will participate in two group meetings per week. As the offender progresses, he/she will participate once per week. Upon issues of relapse, the offender's program will be adjusted as part of the case management process. For example, with approval of the DDOC, the offender may come and spend the weekend at a CREST Program as part of their intervention plan. During the Aftercare process, offenders will utilize the interactive journal, *Transition Skills*. The content of this journal builds on the content that has been learned in the rest of the treatment process. This journal will help the offender:

1. Identify realistic and unrealistic expectations
2. Build and strengthen healthy relationships
3. Manage your time and prioritize your activities
4. Handle social pressure
5. Deal with resentments and risky thoughts
6. Develop skills that help you make good choices
7. Anticipate how you will respond to authority figures in the community
8. Manager your anger
9. Select individuals who support your goal of avoiding future incarceration

Each week the group will focus on one of the nine transitional skills listed above. Since each of these concepts has been reviewed in the CREST Program, the offenders will have a common base. The appropriate transitional skill can be reviewed and applied to whatever life situations the offender is attempting to resolve. For example, if the offender is conflicted about continuing or resuming a relationship in which his partner also has an active using pattern, the skills taught in "Building a Healthy Relationship" can be applied to that situation.

As part of the Aftercare Treatment process, there will be biweekly checks with the offender on how well they are following their Maintenance Plan. On a bimonthly plan, the offender will also be directed to review his/her Personal Statement of Change and report on challenges and successes. As mentioned previously, when offenders are having relapse issues, a case management meeting will be held to review what interventions are needed. The offender will be part of this process. Interventions may range from the offender attending more meetings; to spending weekends at a CREST Program; to a potential return to custody.

6 for 1 Program

The 6 for 1 Program is a modified therapeutic community designed for detainees facing charges that are drug and alcohol related. This voluntary program for unsentenced offenders referred by the Department of Correction has a capacity of 80 males and is housed in the Howard R. Young Correctional Institution. The

purpose of the program is provide an opportunity for the detainees to evaluate the circumstances they have placed themselves in and do a self assessment to determine if and what changes are required in order to live a drug and crime free lifestyle. In this short intense program, with an average length of stay between 30- 45 days, the detention population will have the opportunity to:

- Learn about the negative effects of alcohol and other drugs
- Learn about the negative effects of antisocial thinking and criminal behavior patterns
- Learn relapse prevention and social reintegration skills
- Learn effective interpersonal, anger management, and problem solving skills
- Participate in a 12-Step Fellowship
- Develop an intensive continuing recovery care plan to be facilitated by referral to a community-based and/or residential substance abuse treatment program

The program consists of two phases: *Orientation* and *Phase II*. In order to maximize the limited time available to impact the lives of the detainees, they work in parallel tracks on *Substance Abuse* (see **Attachment O**) and *Basic Cognitive Skills* upon completion of *Orientation*.

In the Orientation Phase, the clients are introduced to the concept of a Modified therapeutic community. The curriculum utilizes the *Introduction to the Therapeutic Community* journal which includes the following objectives for the detentioner to learn:

- Understand how to work together to bring about positive change
- Explore the structure and function of a therapeutic community
- Learn the cardinal rules
- Examine your role as a member of the community
- Consider important concepts within the community
- Learn therapeutic community Tools

The learning of the therapeutic community structure and the assignment of job functions provides an opportunity for the detentioners to behave in pro-social ways. The therapeutic community provides the social structure in which the detentioner can learn about issues concerning alcohol and drug use as well as one's thinking patterns and the connection to how they decide to behave.

The Phase 2 Curriculum utilizes the *Substance Abuse* and the *Basic Cognitive Skills* journals to facilitate the offenders efforts to perform a self assessment of their substance use and how their self-defeating behaviors and unhealthy feelings are the products of distorted thoughts and beliefs.

The *Substance Abuse* journal includes the following objectives:

- Evaluate your substance use and the consequences of using
- Identify strengths and abilities that can help you change your substance use behavior
- Consider your motivations for changing your behavior

- Learn to recognize warning signs that may indicate a return to problem behaviors
- Develop a personalized plan to help you maintain your recovery

The initial task is a self evaluation of one's substance abuse use and resulting consequences. This is designed to raise the consciousness of the detentioner and at least move the detentioner to *contemplation* and push towards *preparation*. Once the detentioner reviews the positive and negative impact of substances, he/she is directed to review one's motivation for change. As part of this review, the detentioner completes an assessment of his/her strengths and abilities. Detentioners then explore "what recovery is" and recognizing one's warning signs. The last set of exercises provides direction for developing one's Recovery Maintenance Plan. As part of the Substance Abuse sequence, the detentioner learns about the 12-Step Fellowship and will be connected with sponsors as appropriate.

Basic Cognitive Skills is the third interactive journal which we propose to utilize in the 6 for 1 Curriculum. The objectives include:

- Learning how self-defeating behavior and unhealthy feelings are the products of distorted thoughts and beliefs
- Learning and applying the "Five Rules for Rational Thinking"
- Learning how to conduct an RSA to check your thinking for distorted beliefs and to control how you think and feel

Basic Cognitive Skills

Basic Cognitive Skills provides information and applications to assist the detentioner in understanding their feelings and thoughts and how the interactions of one's feelings and thoughts impact the type of choices one makes and the resulting behavior. The detentioner is taught the ABCs: Activating Event, Beliefs, and Consequences. By understanding the sequence of the ABCs, the detentioner can begin to learn how one's belief system impacts the response to activating events and the resulting consequences.

Once the detentioner learns the ABCs they are thought the Five Rules for Rational Thinking:

1. Are your thoughts based on objective reality/facts?
2. Are your thoughts helping protect your life and health?
3. Are your thoughts helping you achieve your short-and long-term goals?
4. Are your thoughts helping to keep you out of conflict with others?
5. Are your thoughts leading you to feel the way you want to feel without substance abuse, criminal lifestyle activities, or other harmful, self-defeating behaviors?

The detentioner is guided through the ABCs applying the "Five Rules for Rational Thinking." The goal is to facilitate the detentioner's understanding of his/her thinking process and whether it results in desired consequences.

Young Criminal Offender Program (YCOP)

This program is designed for adolescents 16-18 years of age who have been adjudicated to Superior Court because of the seriousness of their charges and/or convictions. To be admitted to YCOP, the adolescent must be ordered to the program by a judge. A number of these youth have received sentences and will be serving various sentences in the adult system, some up to life in prison. MHM recommends the use of programming materials developed by the Federal Bureau of Prisons in conjunction with the Change Companies. The program BRAVE was developed for young offenders who will serve at least 60 months. The purpose of the program is to help offenders learn how they can live positively even while being incarcerated. All of the skills learned can be applied to how one lives in the community as well. There are three major goals with this program:

1. Development of pro-social values
2. Elimination of inappropriate behaviors
3. Creation of a plan for the future

As noted earlier, the programming will occur within the context of a therapeutic community. There are three Phases to the program: Orientation, Primary Treatment, and Transition. The curriculum will utilize the following interactive journals to facilitate accomplishing the listed goals:

- Introduction to the Therapeutic Community
- Orientation
- Adjustment to Incarceration
- Rational Thinking
- Criminal Lifestyles
- Living with Others
- Lifestyle Balance
- Success Strategies

Phase I: Orientation begins with an *Introduction to the Therapeutic Community*, *Orientation,* and *Adjustment to Incarceration*. *Attitude Checks* and *Rational Self-Analysis* are two of the mainstays in the program element. These tools have been described in the Key Programming section.

In the *Orientation* journal, the offender completes an assessment of what the costs of incarceration are as well as what the benefits might be if one begins to change. Initially, the offender completes an assessment on "what got me here," and then moves to assessing self defeating thoughts that are road blocks to change. In the last section the offender learns about the Attitudes for Successful Change. After the offender completes the *Introduction to the Therapeutic Community* and *Orientation* the next journal is *Adjustment to Incarceration* which has the following objectives:

- Examine the personal impact of your incarceration
- Explore your reactions to losses you've experienced
- Consider constructive ways to adjust to incarceration

In the first segment, offenders are directed to review what losses they have experienced due to incarceration and what their reactions are to those losses. By getting the offender to explore their losses and associated feelings, the chances increase that they will not spend their time incarcerated with the same anti-social behaviors. In the next section, the offender will explore the "harmful ways of coping" with the incarceration experience versus "helpful ways of coping" with incarceration experience. A number of strategies are reviewed to help the offender progress in a positive direction. The strategies are:

- Avoiding incident reports
- Maintaining clear conduct (following the rules)
- Getting along with inmates and staff
- Staying connected with loved ones
- Keeping in touch with your children
- Welcoming visitors

A review of such strategies sets positive expectations for the offenders and enables them to begin to process how they can make the best out of a difficult situation. To complete Phase I of treatment the offender must met the following objectives:

- Be in compliance with the cardinal rules of the therapeutic community
- Following the rules and routines of the therapeutic community
- Attend education classes
- Learn how to do and complete Attitude Checks
- Complete the following interactive journals, *Introduction to the Therapeutic Community, Orientation,* and *Adjustment to Incarceration*

Phase II: The focus of treatment in this phase is habilitation and the development of the offenders' commitment to the therapeutic process. Offenders are immersed in their roles within the community, daily therapeutic processes, and skill development regimens to include meetings, groups, job functions, education, and peer counseling. During this period, participant motivation is changed from one of "need to conform" to one of commitment, a personal resolve to complete the treatment program for one's self. *Rational Thinking* (which has been described earlier in the Key Program) is the first interactive journal utilized in Phase II. Once the offender completes this interactive journal, he/she will be able to do both Attitude Checks and RSA. The next three programming elements the staff will work with offender are *Criminal Lifestyles, Living with Others,* and *Lifestyle Balance* (also described in the Key program). The BRAVE journals have been edited so that the content is appropriate for young offenders, but the basic concepts are the same. To complete Phase II of treatment the offender must accomplish the following:

- Remain in compliance with the rules and routines of the treatment community
- Maintain compliance of the educational goals
- Complete and apply concepts learned in the four interactive journals: *Rational Thinking, Criminal Thinking, Living with Others,* and *Lifestyle Balance*

Phase III: Participants continue to participate in all therapeutic community processes, and begin assuming the roles assigned to the most senior members of the community. Giving back to the community becomes a treatment goal. Successful offenders will be able to recognize that recovery and continuing growth are life-long processes and that the outcome is worth the effort. A distinctive marker of the depth of integration is a change in the offender's self-concept and use of positive self-labeling terms and the identity that is perceived by others. The final interactive journal used to help the offender set positive goals for the future is *Success Strategies*. The objectives are:

- Consider the meaning of success and how to achieve it
- Set and evaluate your goals for the future
- Examine four strategies for success
- Explore four setbacks that can detour you from the road to success: Negative Attitudes, Lifestyle Imbalances, Temptation Thinking, and Unresolved Conflict in Relationships.
- Develop your "Statement of Commitment."

To successfully complete the program, offenders must accomplish the following:

- Consistently follow the rules and routines of the program
- Maintain enrollment in prescribed education classes
- Complete the interactive journals and be able to apply the concepts presented
- Complete and present a "Statement of Commitment"

It is understood that some of the offenders in the program will not be able to complete all programming because they will be transferred at the time of their eighteenth birthday or upon release from custody. For those offenders who remain under DDOC supervision and are eligible for Level IV supervision, it is recommend they would transfer to the appropriate CREST Program and/or Aftercare program to assist them in a successful transition back to the community.

Boot Camp

Boot Camp is a six month program divided into three phases: The focus of Phase I is on military-style discipline and life skills. Phase II focuses on drug treatment and community services and Phase III focuses on job-seeking and acquiring the personal skills that will facilitate successful re-entry into the community.

Eligibility for Boot Camp

We understand eligibility for boot camp as follows:

- Must be 18 years of age
- Must have been sentenced to a period of incarceration of 5 years or less
- Must be physically and mentally capable of successfully completing the rigorous boot camp program (in accordance with the Bureau of Prison's assessment and

determination)
- Must have a term of no less than 9 months with no more than 18 months remaining in Level V incarceration
- Must voluntarily enroll

Once cadets graduate from Boot Camp, they are required to participate in Aftercare Services, meeting with their probation officers twice weekly as well as participate in substance abuse services weekly.

Given the conditions for participating in Boot Camp, cadets are provided the opportunity to develop skills so they are well equipped to return to the community; remain crime and substance free; and become productivity members of the community.

To facilitate the cadets' learning experience the following interactive journals, described previously, are utilized:

- Substance Abuse
- Basic Cognitive Skills
- Living with Others

Cadets are given an opportunity to assess their current functioning, whether the topic is substances, cognitive functioning, or how to live responsibly with self and others. Depending on the individual needs of the cadets, other programming materials (described throughout this proposal) can be utilized.

C.2. TREATMENT CONTENT

The substance abuse programs will contain the following treatment components:

- **Assessment**
- **Individualized treatment planning**
- **Individual and group counseling**
- **Urinalysis testing**
- **Addiction education**
- **Life-management skills**
- **Relapse prevention**

MHM acknowledges, accepts, and will comply with the above requirements.

- **Assessment** – The assessment tool that will be utilized for each of the programs (with the exception of YCOP which will use the CARE-2) will be the DAPPER. This tool measures appropriate treatment placement as well as other dynamic factors to be addressed in treatment. Please refer to *Section D, ii Assessments*, below.

- **Individualized Treatment Planning** – Within the first seven days, an initial Individualized Treatment Plan (ITP) will be completed for all offenders in treatment. A case management meeting will be held at the end of each phase of treatment during which the ITP will be reviewed and updated, as necessary.

- **Individual and Group Counseling** – Group counseling will be the Key component for providing treatment interventions. It will be supplemented with individual counseling, as clinically indicated (e.g., decompensation regarding a certain event or topic that requires immediate or ongoing intervention). Please refer to the sample treatment schedule (**Attachment P**) for an example of the frequency of group counseling and the range of activities to be offered each week.

- **Urinalysis –** Please refer to *Section B.9, Urinalysis,* above.

- **Addiction Education** – *Drug Use* is explored during Phase I of the Key Program using the *Orientation* Journal.

- **Life Management Skills –** We propose that life management skills be covered in Phase II of treatment. There are specific interactive journals which are used with this segment (i.e., *Living with Others, Lifestyle Balance*). *Living with Others* includes the following topics: managing one's emotions, positive and negative relationships, effective communication, anger management, road-blocks to positive attitudes. In the following journal, *Lifestyle Balance,* we focus on the offenders' physical health, emotional health, job satisfaction, and community involvement.

- **Relapse prevention:** Relapse intervention is addressed in the CREST Program using the journal *Recovery Maintenance.* For more information, please refer to *Section C1,* above**.**

C.3. Substance Abuse Education Curriculum

Phase I education will include, but will not be limited to, the following topics:

- **Disease concept**
- **Pharmacology/physical aspects**
  - **Alcohol**
  - **Marijuana**
  - **Other drugs**
- **Denial/criminal thinking errors**
- **Introduction to 12-step programs**
- **AIDS/STDs infectious diseases**
- **Fetal alcohol syndrome and effects**
- **Relapse prevention**
- **Recovery**
  - **Family dynamics**
  - **Cultural issues**
  - **Gender issues**
- **Post acute withdrawal symptoms**

It may be appropriate for trained, senior participants of the substance abuse programs, under staff supervision, to provide education components to other offenders. If the Vendor is considering such an approach, it should be described in

general terms.
MHM will provide the education curriculum delineated above in both Phases I and II of treatment. As mentioned previously, Phase I is used chiefly for orienting offenders to the therapeutic community, providing expectations of the treatment process, and introducing pro-social behaviors. Primary treatment occurs in Phase II.

We will train offenders to lead presentations to other offenders (under staff supervision) covering topics such as the Pharmacological/Physical Aspects of Alcohol, Marijuana, and Other Drugs; AIDS/STDs and Infectious Diseases; and Introduction to 12-step programming. These presentations would be primarily offered to offenders in Phase I and Phase II programming.

- Disease concept (studying the movement from "use" to "abuse" to "addiction" and its physiological results) and pharmacology are addressed in the *Orientation Manual* and will be supplemented by additional handouts. Offenders will complete a self-assessment in Phase I and will describe what side effects of abuse they have experienced.

- Denial and criminal thinking errors are addressed in Phase II of treatment using the *Criminal Thinking* module.

- Offenders will be introduced to 12-step programming including Alcoholics Anonymous and Narcotics Anonymous. MHM will seek to establish relationships with outside 12-step program counselors and invite them to offer presentations to the offenders prior to release in order to increase awareness of the program.

- AIDS/STD information and alcohol fetal syndrome and effects will be provided through handouts and discussion.

- Relapse prevention is covered in the CREST portion of the program for those transitioning from the Key program. If an offender is going to be directly discharged from a Key Program, relapse prevention and transition issues will be covered in the last phase of the Key program.

- Recovery issues are highlighted in the following interactive journals: *Living with Others*, *Lifestyle Balance, Recovery Maintenance,* and *Transition*. Gender-specific, trauma-informed treatment is provided in *Trauma.* Special presentations will be offered concerning how ones' culture impacts ones' perception of the world.

- We will work with mental health staff for those individuals diagnosed with PTSD to ensure that proper programming is provided. As described in the Key section of programming, there are two additional interactive journals, *Co-occurring Disorders* and *Trauma*. These interactive journals would be utilized after consultation with mental health. We will also supply the offenders with information in handouts regarding post-acute withdrawal symptoms reviewing the long-term effects of substance abuse and what steps can be taken to address issues such as depression,

feelings of guilt, lack of initiative, craving, and memory problems, to name a few.

C.4. TREATMENT TOPICS

Phase II primary care will concentrate on, but will not be limited to, the following treatment topics and activities:

- **Cognitive skills building**
- **Sober living skills**
- **Parenting**
- **Goal setting**
- **Values clarification**
- **Criminal thinking**

MHM will address each of the treatment topics above, but proposes to address them throughout the program, rather than limiting them to Phase II.

Cognitive skills building: We have an entire module/interactive journal dedicated to *Rational Thinking* in which cognitive skills building is addressed and offenders learn to do an RSA, identify thinking errors, and learn strategies to think objectively (***see Section C.1*** and (see **Attachment 3**).

Sober Living Skills: Sober living skills are covered in *Lifestyles Balance, Recovery Maintenance*, and *Transition*. For example, *Lifestyles Balance* focuses on one's emotional health, healthy relationships, examining job satisfaction, and one's community involvement. When individuals enter recovery and are doing their best to stay in recovery, relationship issues can often act as a trigger to relapse. Therefore, examining a healthy relationship, assessing current relationships, looking at positive attitudes for healthy relationships, and making decisions as to whether or not these work is a critical part of preparing for successful reentry to the community.

Parenting: The interactive journal on *Living with Others* is a review of the basic dynamics involved in healthy and unhealthy relationships. Concepts learned here can be applied to child rearing. Other materials (i.e., handouts, brochures, etc.) will be utilized to teach appropriate parenting skills.

Goal Setting: MHM staff will work with the offenders in *Recovery Maintenance* and *Transition* to develop a range of goals concerning their recovery and lifestyle balance. For example in *Transition*, the offender sets a goal by completing a personal statement of change. As part of that statement, the offender is asked "Knowing myself as I do, what do I need to do to get where I want to go?" and "What pitfalls are there to watch out for?" The responses to these questions will be reviewed with the offender as well as other goals that have been developed to determine the practicability of the goals. Some offenders will express doubts about their ability to remain substance and crime free upon release. Therefore, offenders will be continually challenged about their stated goals and what they have done or not done to prepare for a pro-social lifestyle.

Values Clarification: This is addressed in both the segment on *Rational Thinking* and

Criminal Lifestyles. In *Rational Thinking*, offenders will be taught ten different "irrational thinking errors" as well as "Five Rules for Rational Thinking." This process helps them to better understand their beliefs/values and how they may or may not be distorted. In *Criminal Lifestyles*, offenders will be presented with ten different "criminal thinking errors," and how to change their thinking in a pro-social manner.

Criminal Thinking: As described previously, there is a whole segment in Phase II treatment on *Criminal Lifestyles* which provides an opportunity for the offender to learn about their criminal thinking and behavior. As part of that process, MHM staff will assist offenders in looking at both the positives and negatives of their criminal activity.

C.5. Additional Treatment Activities

Generally speaking, the substance abuse treatment participants are separated from the general offender population during daily routines. However, they may participate in other classes and work assignments within the institution as a part of their individualized treatment plans or as deemed appropriate by DDOC classification staff. In doing so they will have the opportunity to apply newly acquired treatment knowledge and recovery skills in the correctional settings. They will also have access to other necessary support services such as religious programs and mental health and medical services.

MHM acknowledges, accepts, and will comply with the above requirements.

As offenders progress in treatment, they are expected to be positive role models within the institution. Upon agreement with facility administration, offenders may provide presentations to the general population (under supervision) discussing the advantages of participating in treatment drug programming or offering seminars on HIV/STDs or other topics, such as how to do Rational Self Analysis (RSA). They may also be able provide presentations for the young offenders in YCOP and/or the 6 for 1 Program, as approved by the DDOC.

Additionally, offenders in Phase III of treatment may be able to hold a job assignment within the institution provided it does not conflict with their treatment programming. Offenders who have demonstrated responsibility as Department Heads (see the *Structure Board*) will be eligible for these job assignments (such as maintenance, janitorial duties, kitchen crew, etc.).

D. General Requirements

Vendor must include in their plan for services each of the following work requirements:

i. **Treatment Methodology:**
ii. **Assessments:**
iii. **Evaluation Plan Requirement**

iv. **Coordination Requirements**
v. **Working Hours**
vi. **Program Alteration**
vii. **Experience**
viii. **Clerical Assistance**
ix. **Data Requests**
x. **Confidentiality of Records**
xi. **Testimony**

MHM acknowledges, accepts, and will comply with the General Requirements in *Section XI, D* of the RFP.

i. Treatment Methodology

It is understood that the treatment methodology proposed must be approved by the DDOC, BCHS. MHM's treatment methodology described in ***Section B, Program Description*** details the *Phases of Change*, Therapeutic Community Treatment Model, and interactive journaling which will be reviewed with DDOC BCHS for approval.

ii. Assessments

The UNCOPE, developed by Norman Hoffman, PhD, and his colleagues (1999), is recommended as a screening tool for mental health staff to use as part of our screening process. The tool has six questions and can be scored quickly to determine the likelihood of an individual having a substance abuse/alcohol issue. This screening tool will also be utilized for offenders referred to one of the drug treatment programs after commitment to the DDOC.

The DAPPER, *Dimensional Assessment for Patient Placement, Engagement & Retention* (by Norman G. Hoffmann, Ph.D., David Mee-Lee, M.D., and Gerald D. Shulman, M.A., M.A.C., FACATA) is recommended as the assessment tool for offenders admitted to one of the drug treatment programs. The DAPPER is based upon the ASAM PPC–2R (American Society of Addiction Medicine, Patient Placement Criteria – 2 Revised) and uses ratings to form subscales within each of the six assessment dimensions of the ASAM patient placement criteria. The Dimensions covered are as follows:

1. Acute Intoxication / Withdrawal Potential
2. Biomedical conditions / Complications
3. Emotional / Behavioral / Cognitive Conditions and Complications
4. Readiness to Change
5. Relapse / Continued Use / Continued Problem Potential
6. Recovery Environment.

The DAPPER will be used for the initial assessment and treatment planning for all drug treatment programs. The Dapper will also be utilized after the offender has been in the Key program for six months to determine progress or the lack of progress. It is also recommended that the DAPPER be administered after three months of participation in the

CREST Program. If the offender is beginning treatment at a CREST Program, then the DAPPER will be administered at the point of entry.

Counseling staff will be trained on the administration of the DAPPER. The DAPPER can be administered and scored electronically or manually. Dependent upon computer access, a determination will be made on which format will be utilized.

For the YCOP program, the CARE-2 (developed by Kathryn Seifert, PhD) will be used as the assessment tool to determine the most clinically appropriate treatment interventions for the offenders in the Young Criminal Offenders Program. This tool is designed to identify youth who are at-risk for violence and to determine appropriate interventions needed to prevent any future risk of violence. The CARE-2 also provides a case management planning tool which assists the clinician in developing treatment plans. The tool can also be used to monitor progress and review treatment planning through the course of the program.

iii. Evaluation Plan Requirement

MHM has developed a draft of our evaluation plan, included below. For each of the substance abuse programs, we have established goals and measurements to determine the extent to which the services were successfully implemented and the success of the service in achieving effective program outcomes.

From the data we collect, we will develop and provide reports to the State quarterly. We will develop action plans for areas that are significantly below our set goals.

PROGRAM OBJECTIVES	
TITLE/OBJECTIVE OF GROUP	**TARGET**
KEY PROGRAM The objectives for Key North, Key South, and Key Village group is to provide all offenders referred for treatment consideration to be screened using the UNCOPE An offender with a score of 2 or more will be considered for admission. Once offenders are admitted to a program they will be assessed within 3 working days utilizing the Dimensional Assessment for Patient Placement, Engagement and Retention (DAPPER). The assessment will include a summary reflecting one's bio/psycho social information including the DDOC sentencing information. All offenders will receive an initial treatment plan within 5 working days of the completion of the DAPPER and bio/psycho social information. The objective is to provide all newly admitted offenders to complete Phase III in the defined time lines.	• 90 % of treatment beds to be kept occupied on an annualized basis • Offender to be screened using UNCOPE within 10 working days of referral • Offender with a score of 2 or more will be admitted • All Offenders assessed within 3 working days utilizing DAPPER • All Offender receive an initial treatment plan within 5 working days after assessment • 85% of the Offenders beginning Orientation (Phase I) will complete Orientation within 90 Days. • 75% of the Offenders transitioning to Phase II will complete Phase II treatment within 210 days. • 70 % of the Offenders transitioning to Phase III will complete Phase III within 60 days.

PROGRAM OBJECTIVES	
TITLE/OBJECTIVE OF GROUP	**TARGET**
CREST PROGRAM The objectives for CREST North, CREST Central, CREST South and CREST North Program for Women are to assess all new admissions to treatment at Level IV within 3 working days utilizing the DAPPER, and have treatment plans completed within 5 working days of the completed assessment. Treatment plans for admissions transferring from Key program to be reviewed and updated within 3 days of admissions to the CREST Program. All clients in Phase II will have approved employment and or school enrollment. All clients transitioning to Aftercare will have approved employment and or school enrollment and approved housing.	• 90 % of treatment beds will be occupied on an annualized basis • New admission to treatment at Level IV to be assessed using the DAPPER within 3 working days • Treatment plans to be completed within 5 working days of the completed assessment • Treatment plans for admissions transferring from Key Programs to be reviewed and updated within 3 days to the CREST Program • 85% of those admitted to the program will finish Orientation within 30 days of admission and transition to Phase II • 75% of those completing Orientation will complete Phase II Programming within 60 Days and transition to Phase III • 70% of those completing Phase II Programming will complete Phase III Programming within 90 days and transition to Aftercare .
AFTERCARE PROGRAM The objective of the Aftercare Program is to ensure that 80% of clients who transition to Aftercare will successfully complete it. The program's objective is to ensure that all Offenders transitioning to Aftercare will have approved housing as well as work or will be attending some type of schooling. All Offenders will have their assessment and treatment plan reviewed within the first 5 days of their transition to Aftercare. Any offender having relapse will be placed in the relapse intervention sequence.	• 80% of the clients who transition to aftercare will successfully complete aftercare. • 100% of offenders transitioning to aftercare will have approved housing as well as work and or be attending some type of schooling • 100% of offenders transitioning to aftercare will have their assessment and treatment plan reviewed within the first 5 days of transition to aftercare • 100% of the Aftercare clients in Phase I will participate in two groups per week as well as two AA/NA groups per week. • 100% of the Aftercare clients in Phase II will participate in one group per week as well as two AA/NA groups per week.
6 FOR 1 PROGRAM The objectives for the program are as follows: • All detainees committed to the program will be provided an assessment using the DAPPER from which a treatment plan will be written within 3 days of admission • All detainees completing the program will complete the interactive journal, "*Introduction to Therapeutic Community."* • All detainees completing the program will complete the interactive journal, "*Substance Abuse*." • All detainees completing the program will complete the interactive journal, "Cognitive Skills."	• 95% of the admitted detainees will complete the program • 100% of detainees completing the program will have developed a re-entry plan

PROGRAM OBJECTIVES	
TITLE/OBJECTIVE OF GROUP	**TARGET**
YOUNG CRIMINAL OFFENDER PROGRAM (YCOP) The objectives for this program are to assess the Offenders using the CARE-2 to develop an initial treatment plan within five days of admission to the program. The program's goal is to ensure Offenders admitted to the program are maintained in the program until they are classified to other housing and/or released from custody. The program's objective is also to ensure the Offenders in the program complete interactive journals and participate in education classes as scheduled by the education department.	• 100% of the offenders will be assessed using the CARE-2 and an initial treatment plan will be developed within five days of admission to the program • 100% of the offenders admitted to the program will be maintained in the program until they are classified to other housing and/or released from custody. • 100% of the offenders in the program will complete the interactive journal "*Introduction to the Therapeutic Community."* • 100% of the offenders in the program will complete the interactive journal "*Orientation*." • 100% of the offenders in the program will complete the interactive journal "*Adjustment to Incarceration*." • 100% of the offenders in the program will complete the interactive journal "*Rational Thinking*." • 100% of the offenders in the program will complete the interactive journal "*Criminal Lifestyles*." • 100% of the offenders in the program will complete the interactive journal "*Living with Others*." • 100% of the offenders in the program will complete the interactive journal "*Lifestyle Balance*." • 100% of the offenders in the program will complete the interactive journal "*Success Strategies*." • 100% of the offenders in the program will participate in education classes as scheduled by the education department
BOOT CAMP PROGRAM AT SUSSEX CORRECTIONAL INSTITUTION The focus of the program will be on substance abuse education and cognitive restructuring.	• 100% of the Cadets admitted to Boot Camp will be assessed using the DAPPER within the first 10 days of admission • 100% of the Cadets assessed will have a treatment plan within 12 days of admission • 100% of the Cadets in Boot Camp will complete the interactive journal "*Living with Others*." • 100% of the Cadets in Boot Camp will complete the interactive journal "*Substance Abuse*" • 100% of the Cadets in Boot Camp will complete the interactive journal "*Basic Cognitive Skills."* • 100% of the Cadets graduating from Boot Camp will have a written re-entry plan

iv. Coordination Requirements:

As described previously, we will coordinate with the medical vendor for offenders in need of physical health care. We will work closely with them in supporting the medical treatment plan for the offender, and will notify the medical vendor of any difficulties with the offender.

Training. MHM will offer training on a quarterly basis for vendors within the facility, appropriate DDOC staff, and community agencies that provide services for offenders upon release. This training will include:

- Phases and Processes of Change
- Introduction to the Therapeutic Community
- Rational Self-Analysis
- Attitude Checks
- The Dynamics of Interactive Journaling
- Therapeutic Communication
- PREA Sensitivity Training
- Treatment Planning Introduction
- Treatment Goals and Interventions
- Documenting Progress under a Treatment Plan
- Reviewing and Updating Treatment Plans
- Clinical Boundaries and Safe Practices
- Working with Incarcerated Women
- Conducting Groups in Corrections
- Introduction to Mental Illness
- Mental Illness in Corrections
- Confidentiality in Corrections

Release/Sharing of Offender Information: A release of information will be signed and discharge treatment plans will be shared with the necessary community providers. When offenders transfer to the CREST program, the ITP will be reviewed and modified.

MHM's Assistant Program Managers will meet with each of the county's prospective Chief Probation and Parole Officers to review the sharing of information about common clients and probation and aftercare treatment expectations.

v. Working Hours

MHM will develop treatment staff work schedules at the different treatment programs to fit within the needs of the individual institutions' schedules. MHM would like to provide 12 hours of coverage during the week for the Key and CREST Programs and 8-9 hours of coverage on the weekends. Coverage for the 6 for 1 Program and the YCOP program will vary somewhat depending on the number of staff positions. Dependent upon the final staffing patterns for each of the programs, working hours will be determined in concurrence with the facility administrators. For our initial work schedule, see *Section G.*

vi. Program Alteration

During the course of the contract, MHM will work with the DDOC Substance Abuse Treatment Administrator in making any significant program alterations to the therapeutic community. MHM will submit in writing any significant proposed changes, and will obtain pre-approval by the DDOC Substance Administrator or designee prior to making any significant changes.

vii. Experience

Counselors hired to work in the substance abuse programs will be knowledgeable in drug and alcohol counseling and will have experience working with those with a criminal

mind set. Recruiting will focus on individuals who have knowledge and expertise working in a therapeutic community, especially in a correctional environment.

viii. Clerical Assistance

Clerical assistance will be provided for all of the programs and is included in MHM's staffing plan.

ix. Data Requests

MHM will provide basic data to the institutional Warden or the DDOC Substance Abuse Treatment Services Administrator, upon request.

x. Confidentiality of Records

Given the importance of protecting the client/therapist privilege and confidentiality of offender records, MHM will comply with the State of Delaware and federal statues governing offender's confidentiality. For further information, please refer to *Tab 5, Section IV, p.*

xi. Testimony

MHM staff will testify regarding an offender upon receipt of a court order.

E. Reporting Requirements

a) Performance Measure Reporting: As stated DDOC will implement performance measures in conjunction with the State's performance based budgeting. MHM will comply with the additional simple data collecting and reporting requirement as requested by the DDOC.
b) Data Entry: MHM will utilize DACS as required by the DDOC.
c) Other Reporting: Upon request MHM will submit such other information and reports relating to its activities under this contract on such forms and at such times as may be required by the DDOC substance abuse treatment services administrator.
d) Offender Tracking System: MHM will establish an offender tracking systems for follow up/aftercare services in a community residential centers and /or community agency.
e) Progress Reports: MHM will routinely provide progress reports on offenders to the DDOC staff and upon request, special reports to the parole board.
f) Treatment Compliance: MHM will assist in the DDOC compliance with State of Delaware laws as they apply to substance abuse treatment. Specifically MHM will be required to…

MHM acknowledges, accepts, and will comply with all substance abuse reporting requirements as listed in *Section XI, E* of the RFP.

F. Continuing Education Requirement

The Vendor must assure, at no cost to the State that their program managers working under the terms of the contract meet and maintain the legal requirements for certification. Continuing education hours are not billable to the State.

MHM acknowledges, accepts, and will comply with the above requirements. MHM will assure, at no cost to the State, that our Program Managers meet and maintain the legal requirements for certification.

In addition to the training services MHM provides, we also incentivize employees to participate in continuing education activities and provide each employee with a continuing education allowance as part of our benefits plan. This allowance is helpful for employees who must participate in certified continuing education programs to maintain licensure. We have also found this benefit helpful in reducing turnover and highly appreciated by our clinical staff.

G. Work Schedule

Vendors are to propose a staff work schedule detailing the number of weeks, days, and total hours anticipated annually for each position.

Each full time position is based on 2,080 hours per year. Full-time staff are expected to provide eight hours of service per day, five days per week. As indicated in *Section D.v,* there will be weekend coverage for each of the programs with the exception of Boot Camp. Coverage is dependent upon the number of staff proposed for each program as is demonstrated in the sample work schedule which follows. The final work schedule will be determined by the Program Manager, Assistant Program Managers, and DDOC upon contract award.

Staffing Patterns
Level V
Howard R. Young Correctional Institution
Key North Program

	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1
Monday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: 1 Clinical Supervisor: 1 Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Tuesday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: 1 Clinical Supervisor: 2 Counselors: 6	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 3
Wednesday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: 1 Clinical Supervisor: 2 Counselors: 6	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 3
Thursday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: 1 Clinical Supervisor: 2 Counselors: 5	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 4
Friday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: 1 Clinical Supervisor: 2 Counselors: 3	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 3
Saturday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: 1 Counselors: 3	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2

Positions:
Assistant Program Manager: 1.0
Administrative Assistant: 1.0
Clinical Supervisor: 2.0
Counselors: 9.0

Staffing Patterns
Level V
Howard R. Young Correctional Institution
6 For 1 Program

	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 5:00 p.m.	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors:
Monday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: 1 Clinical Supervisor: Counselors: 1	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Tuesday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: Clinical Supervisor: Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Wednesday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: 1 Clinical Supervisor: Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Thursday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: Clinical Supervisor: Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Friday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: Clinical Supervisor: Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors:1
Saturday 8:00 a.m. – 5:00 p.m.	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors:

Positions:
Assistant Program Manager: 1.0
Administrative Assistant: 0.30
Counselors: 4.0

Staffing Patterns
Level V
Howard R. Young Correctional Institution
Young Criminal Offender Program

	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 5:00 p.m.	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors:
Monday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: Clinical Supervisor: Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1
Tuesday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: Clinical Supervisor: Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1
Wednesday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: Clinical Supervisor: Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1
Thursday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: 1 Clinical Supervisor: Counselors: 1	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1
Friday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: Clinical Supervisor: Counselors: 1	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1
Saturday 8:00 a.m. – 5:00 p.m.	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors:

Positions:
Assistant Program Manager: 1.0
Administrative Assistant: 0.20
Counselors: 3.0

Staffing Patterns
Level V
Baylor Women Correctional Institution
Key Village Program

	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1
Monday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: 0.5 Administrative Assistant: 0.5 Clinical Supervisor: 1 Counselors: 1	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1
Tuesday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 0.5 Administrative Assistant: 0.5 Clinical Supervisor: 1 Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Wednesday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 0.5 Administrative Assistant: 0.5 Clinical Supervisor: 1 Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Thursday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 0.5 Administrative Assistant: 0.5 Clinical Supervisor: 1 Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Friday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 0.5 Administrative Assistant: 0.5 Clinical Supervisor:1 Counselors: 1	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1
Saturday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1

Positions:
Assistant Program Manager: 0.50
Administrative Assistant: 0.50
Clinical Supervisor: 1.0
Counselors: 4.0

Staffing Patterns
Level V
Sussex Correctional Institution
Key South Program

	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1
Monday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: 0.5 Administrative Assistant: 0.9 Clinical Supervisor:1 Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1
Tuesday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 0.5 Administrative Assistant: 0.9 Clinical Supervisor: 1 Counselors: 3	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Wednesday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 0.5 Administrative Assistant: 0.9 Clinical Supervisor: 1 Counselors: 3	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Thursday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 0.5 Administrative Assistant: 0.9 Clinical Supervisor: 1 Counselors: 3	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Friday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 0.5 Administrative Assistant: 0.9 Clinical Supervisor: 1 Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1
Saturday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1

Positions:
Assistant Program Manager: 0.50
Administrative Assistant: 0.90
Clinical Supervisor: 1.0
Counselors: 5.0

Staffing Patterns
Level V
Sussex Correctional Institution
Boot Camp Program

	A.M. Shift	P.M. Shift
Sunday		
Monday 8:00 a.m. – 5:00 p.m.	Assistant Program Manager: Administrative Assistant: .1 Clinical Supervisor: Counselors: 1	
Tuesday 8:00 a.m. – 5:00 p.m.	Assistant Program Manager: Administrative Assistant: .1 Clinical Supervisor: Counselors: 1	
Wednesday 8:00 a.m. – 5:00 p.m.	Assistant Program Manager: Administrative Assistant: .1 Clinical Supervisor: Counselors: 1	
Thursday 8:00 a.m. – 5:00 p.m.	Assistant Program Manager: Administrative Assistant: .1 Clinical Supervisor: Counselors: 1	
Friday 8:00 a.m. – 5:00 p.m.	Assistant Program Manager: Administrative Assistant: .1 Clinical Supervisor: Counselors: 1	
Saturday		

Positions:
Assistant Program Manager:
Administrative Assistant: .10
Clinical Supervisor:
Counselors: 1.0

Staffing Patterns
Level IV
Plummer Community Correctional Center
CREST North Program

	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1
Monday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: 1 Clinical Supervisor: 1 Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Tuesday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: 1 Clinical Supervisor: Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 3
Wednesday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: 1 Clinical Supervisor: 1 Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 3
Thursday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: 1 Clinical Supervisor: Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 3
Friday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: 1 Clinical Supervisor: 1 Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 3
Saturday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Plummer Community Correctional Center Aftercare Program P.M. Shift Coverage Sunday through Saturday		

CREST North Program **Positions:**	**Aftercare Program** **Positions:**
Assistant Program Manager: 0.70 Administrative Assistant: 0.70 Clinical Supervisor: 0.70 Counselors: 6.0	Assistant Program Manager: 0.30 Administrative Assistant: 0.30 Clinical Supervisor: 0.30 Counselors: 3.0

Staffing Patterns
Level IV
Women Work Release Treatment Center
CREST North Program for Women

	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1
Monday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: 0.3 Administrative Assistant: 1 Clinical Supervisor: 1 Counselors: 1	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1
Tuesday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 0.3 Administrative Assistant: 1 Clinical Supervisor: 1 Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Wednesday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 0.3 Administrative Assistant: 1 Clinical Supervisor: 1 Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Thursday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 0.3 Administrative Assistant: 1 Clinical Supervisor: 1 Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Friday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 0.3 Administrative Assistant: 1 Clinical Supervisor: 1 Counselors: 1	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1
Saturday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1
Women Work Release Treatment Center Aftercare Program P.M. Shift Coverage Sunday through Saturday		

CREST North Program for Women **Positions:**	**Aftercare Program for Women** **Positions:**
Assistant Program Manager: 0.30 Administrative Assistant: 0.80 Clinical Supervisor: 0.70 Counselors: 4.0	Assistant Program Manager: 0.20 Administrative Assistant: 0.20 Clinical Supervisor: 0.30 Counselors: 2.0

Staffing Patterns
Level IV
Morris Community Correctional Center
CREST Central Program

	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: Administrative Assistant: Clinical Supervisor:1 Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Monday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: 1 Clinical Supervisor:1 Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Tuesday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: 1 Clinical Supervisor: 2 Counselors: 4	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Wednesday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: 1 Clinical Supervisor: 2 Counselors: 4	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 3
Thursday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: 1 Clinical Supervisor: 2 Counselors: 4	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Friday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 1 Administrative Assistant: 1 Clinical Supervisor: 1 Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Saturday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: 1 Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Women Work Release Treatment Center Aftercare Program P.M. Shift Coverage Sunday through Saturday		

CREST Central Program Positions:	**Morris Community Correctional Center Aftercare Program Positions:**
Assistant Program Manager: 0.70 Administrative Assistant: .80 Clinical Supervisor: 1.50 Counselors: 7.0	Assistant Program Manager: 0.30 Administrative Assistant: 0.20 Clinical Supervisor: 0.50 Counselors: 2.0

Staffing Patterns
Level IV
Sussex Community Correctional Center
CREST South Program

	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1
Monday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: 0.5 Administrative Assistant: 1 Clinical Supervisor: 1 Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1
Tuesday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 0.5 Administrative Assistant: 1 Clinical Supervisor: 1 Counselors: 3	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Wednesday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 0.5 Administrative Assistant: 1 Clinical Supervisor: 1 Counselors: 3	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Thursday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 0.5 Administrative Assistant: 1 Clinical Supervisor: 1 Counselors: 3	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 2
Friday 7:00 a.m. – 9:00 p.m.	Assistant Program Manager: 0.5 Administrative Assistant: 1 Clinical Supervisor: 1 Counselors: 2	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1
Saturday 8:00 a.m. – 9:00 p.m.	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1	Assistant Program Manager: Administrative Assistant: Clinical Supervisor: Counselors: 1
Sussex Community Correctional Center Aftercare Program P.M. Shift Coverage Sunday through Saturday		

CREST South Program Positions:	**Sussex Community Correctional Center Aftercare Program Positions:**
Assistant Program Manager: 0.30 Administrative Assistant: 0.70 Clinical Supervisor: 0.70 Counselors: 5.0	Assistant Program Manager: 0.20 Administrative Assistant: 0.30 Clinical Supervisor: 0.30 Counselors: 2.0

TAB 7. COST PROPOSAL

Per RFP requirements, we have provided separate pricing for the mental health and substance abuse treatment programs. This tab includes the following:

MENTAL HEALTH

- Pricing Narrative
- Summary Pricing Form
- Detailed Pricing Form by Facility

SUBSTANCE ABUSE

- Pricing Narrative
- Summary Pricing Form
- Detailed Pricing Form by Facility

TAB 7. COST PROPOSAL
MENTAL HEALTH SERVICES

PRICING NARRATIVE

This narrative along with the two accompanying pricing schedules (Summary Pricing Form and Detail Pricing Form by Facility) comprises MHM's pricing proposal for the provision of Mental Health Services for the DDOC. In the development of this pricing proposal, MHM has strived to provide the level of detail, clarity, and transparency of costs requested in the RFP.

The Pricing and Payment section of the RFP for Mental Health Services requested a total cost and a management fee per offender per month. MHM is pleased to offer the following pricing for the initial year of the contract:

Total Annual Cost	Cost Per Offender Per Month (based on an ADP of 8105)
$5,624,937	**$57.83**

This price represents MHM's best effort to provide the most cost-efficient, full-service model of mental health care for the DDOC using our extensive experience in providing mental health services in similar programs, and given the lack of current staffing and other cost details available with the RFP. In an effort to provide the best price to the DDOC, MHM's pricing does not include allowances for staffing penalties or other performance measurement fees.

MHM believes that a fixed price scenario provides the DDOC with the most efficient method of managing the costs of this service and a level of assurance in maintaining funding limits. A fixed price contract also provides the vendor with the flexibility to work with the DDOC to place available resources in areas of highest need. MHM is very familiar with the environment of economic pressures and budgetary constraints facing entities such as the DDOC. MHM has a history of partnering with our clients to meet their needs in managing costs and developing solutions to operational and financial issues. We look forward to a similar partnership with the DDOC.

As requested in Appendix G of the RFP, the components of the above pricing are provided on the Summary Pricing Form, including statewide staffing totals and hourly rates by position, and Operating and Administrative costs. A profit margin of approximately 5% is included in the Administrative costs. Staffing costs by position by facility are provided on the Detail Pricing Form by Facility.

The price proposed for the second year of the contract is an amount equal to the price of the first contract year and the greater of 3% or the most recent CPI-W from the Bureau of Labor Statistics for the Philadelphia, Wilmington, and Atlantic City local area.

MHM Correctional Services
Delaware Mental Health Program
Delaware Department of Correction
Summary Pricing Form
Contract Year One

Staff and Related Costs

Position	FTEs	Salaries & Benefits	Other Direct Staff Costs (1)	Total Staff Cost	Total Cost Per Hour
Activity Tech	3.50	$153,086	$10,500	$163,586	$22.47
Clerk/Med Records Clerk/MH Clerk	4.50	$183,288	$13,500	$196,788	$21.02
NP/PA	1.00	$114,351	$3,000	$117,351	$56.42
MH Director	4.00	$276,903	$12,000	$288,903	$34.72
MH PHD Psychologist	1.00	$82,991	$3,000	$85,991	$41.34
MH Worker	18.32	$992,566	$54,960	$1,047,526	$27.49
MSW/MH Prof/MHW Super.	7.60	$469,369	$22,800	$492,169	$31.13
Psychiatrist	4.10	$1,389,891	$12,300	$1,402,191	$164.42
MH Clerk/Observer	7.00	$222,384	$21,000	$243,384	$16.72
Program Manager	1.00	$118,609	$3,000	$121,609	$58.47
Regional Psychologist	1.00	$98,362	$3,000	$101,362	$48.73
Regional Psych Director	0.20	$64,301	$600	$64,901	$156.01
Regional Administrative Assistant	1.00	$48,846	$3,000	$51,846	$24.93
Sex Offender Treatment Coordinator	2.00	$124,101	$6,000	$130,101	$31.27
Regional Director	0.25	$30,805	$750	$31,555	$60.68
Total Staff and Related Costs	56.47	$4,369,854	$169,410	$4,539,264	

Other Operating Costs (2)	**$6,000**
Facility, Regional, and Corporate Administrative	**$1,079,672**
Aggregate Total	**$5,624,937**
Inmates	**8,105**
PIPM	**$57.83**

(1) Other Direct Staff Costs include: payroll services, credentialing fees, cellular phone expense, malpractice insurance premiums, travel, relocation, training and drug testing.

(2) Other Operating Costs include clinical supplies and equipment.

(3) Local, Region, and Corporate Adminstrative includes (1) direct program expenses for copying and printing; postage and delivery; office supplies, equipment, and services; and performance bond; (2) Regional Office expenses including rent and other facility costs; and (3) Corporate Overhead, which includes, but is not limited to, costs for support functions for contract operations, clinical/quality assurance, recruiting, human resources, information technology, financial reporting, payroll, accounts receivable, accounts payable as well as costs for income taxes. A profit percentage of approximately 5% is included.

MHM Correctional Services
Delaware Mental Health Program
Delaware Department of Correction
Detail Pricing Form By Facility
Contract Year One

Position	FTEs	Salaries & Benefits	Other Direct Staff	Total Staff Cost	Total Cost Per Hour
Facility:	**Sussex CI, WR, & VOP**				
Activity Tech	0.00	$0	$0	$0	$0.00
Clerk/Med Records Clerk/MH Clerk	1.00	$40,731	$3,000	$43,731	$21.02
MH Director	1.00	$69,226	$3,000	$72,226	$34.72
MH Worker	5.40	$292,569	$16,200	$308,769	$27.49
MSW/MH Prof/MHW Super.	1.00	$61,759	$3,000	$64,759	$31.13
Psychiatrist	0.75	$254,248	$2,250	$256,498	$164.42
MH Clerk/Observer	2.00	$63,538	$6,000	$69,538	$16.72
Total Sussex CI, WR, & VOP	11.15	$782,071	$33,450	$815,521	
Facility:	**JTVCC & JTVCC Max**				
Activity Tech	3.50	$153,086	$10,500	$163,586	$22.47
Clerk/Med Records Clerk/MH Clerk	2.00	$81,461	$6,000	$87,461	$21.02
NP/PA	0.50	$57,175	$1,500	$58,675	$56.42
MH Director	1.00	$69,226	$3,000	$72,226	$34.72
MH PHD Psychologist	1.00	$82,991	$3,000	$85,991	$41.34
MH Worker	8.40	$455,107	$25,200	$480,307	$27.49
MSW/MH Prof/MHW Super.	1.00	$61,759	$3,000	$64,759	$31.13
Psychiatrist	1.50	$508,497	$4,500	$512,997	$164.42
MH Clerk/Observer	2.00	$63,538	$6,000	$69,538	$16.72
Total JTVCC & JTVCC Max	20.90	$1,532,840	$62,700	$1,595,540	
Facility:	**Morris**				
MH Worker	0.20	$10,836	$600	$11,436	$27.49
Psychiatrist	0.05	$16,950	$150	$17,100	$164.42
Total Morris	0.25	$27,786	$750	$28,536	
Facility:	**Central VOP**				
MH Worker	0.30	$16,254	$900	$17,154	$27.49
Psychiatrist	0.10	$33,900	$300	$34,200	$164.42
Total Central VOP	0.40	$50,154	$1,200	$51,354	
Facility:	**Howard Young**				
Clerk/Med Records Clerk/MH Clerk	1.00	$40,731	$3,000	$43,731	$21.02
NP/PA	0.50	$57,175	$1,500	$58,675	$56.42
MH Director	1.00	$69,226	$3,000	$72,226	$34.72
MH Worker	2.90	$157,120	$8,700	$165,820	$27.49
MSW/MH Prof/MHW Super.	3.00	$185,277	$9,000	$194,277	$31.13
Psychiatrist	1.00	$338,998	$3,000	$341,998	$164.42
MH Clerk/Observer	2.00	$63,538	$6,000	$69,538	$16.72
Total Howard Young	11.40	$912,066	$34,200	$946,266	
Facility:	**Baylor & Women's VTC**				
Clerk/Med Records Clerk/MH Clerk	0.50	$20,365	$1,500	$21,865	$21.02
MH Director	1.00	$69,226	$3,000	$72,226	$34.72
MH Worker	1.10	$59,597	$3,300	$62,897	$27.49
MSW/MH Prof/MHW Super.	1.50	$92,639	$4,500	$97,139	$31.13
Psychiatrist	0.50	$169,499	$1,500	$170,999	$164.42
MH Clerk/Observer	1.00	$31,769	$3,000	$34,769	$16.72
Total Baylor & Women's VTC	5.60	$443,095	$16,800	$459,895	
Facility:	**J Webb**				
MH Worker	0.02	$1,084	$60	$1,144	$27.49
Psychiatrist	0.05	$16,950	$150	$17,100	$164.42
Total J Webb	0.07	$18,033	$210	$18,243	
Facility:	**Plummer**				
MSW/MH Prof/MHW Super.	1.10	$67,935	$3,300	$71,235	$31.13
Psychiatrist	0.15	$50,850	$450	$51,300	$164.42
Total Plummer	1.25	$118,785	$3,750	$122,535	
Facility:	**Regional Office**				
Program Manager	1.00	$118,609	$3,000	$121,609	$58.47
Regional Psychologist	1.00	$98,362	$3,000	$101,362	$48.73
Regional Psych Director	0.20	$64,301	$600	$64,901	$156.01
Regional Adminstrative Assistant	1.00	$48,846	$3,000	$51,846	$24.93
Sex Offender Treatment Coordinator	2.00	$124,101	$6,000	$130,101	$31.27
Regional Director	0.25	$30,805	$750	$31,555	$60.68
Total Regional Office	5.45	$330,119	$9,600	$339,719	

TAB 7. COST PROPOSAL
SUBSTANCE ABUSE SERVICES

PRICING NARRATIVE

Pricing Narrative

This narrative along with the two accompanying pricing schedules (Summary Pricing Form and Detail Pricing Form by Facility) comprises MHM's pricing proposal for the substance abuse treatment program for the DDOC. In developing this pricing proposal, MHM has strived to provide the level of detail, clarity, and transparency of costs requested in the RFP.

The pricing and payment section of the RFP for substance abuse treatment requested a total cost and a management fee per offender per month. MHM is pleased to offer the following pricing for the initial year of the contract:

Total Annual Cost	Cost Per Offender Per Month (based on an ADP of 8105)
$4,754,285	$48.88

This price represents MHM's best effort to provide the most cost-efficient, full-service model of substance abuse treatment for the DDOC, given the lack of current staffing and other cost details available with the RFP. In an effort to provide the best price to the DDOC, MHM's pricing does not include allowances for staffing penalties or other performance measurement fees.

MHM believes that a fixed price scenario provides the DDOC with the most efficient method of managing the costs of this service and a level of assurance in maintaining funding limits. A fixed price contract also provides the vendor with the flexibility to work with the DDOC to place available resources in the areas of highest need. MHM is very familiar with the environment of economic pressures and budgetary constraints facing entities such as the DDOC.

MHM has a history of partnering with our clients to meet their needs in managing costs and developing solutions to operational and financial issues. We look forward to a similar partnership with the DDOC. In that light, and given that the above pricing is based on the staffing required to operate each unit at available capacity, MHM will work with the DDOC to modify staffing levels if unit capacities are not consistently maintained, and return resulting savings to the DDOC in the form of staffing rebates.

As requested in *Appendix G* of the RFP, the components of the above pricing are provided on the Summary Pricing Form, including statewide staffing totals and hourly rates by position, and Operating and Administrative costs. A profit margin of

approximately 5% is included in the Administrative costs. Staffing costs by position by facility are provided on the Detail Pricing Form by Facility.

The price proposed for the second year of the contract is an amount equal to the price of the first contract year and the greater of 3% or the most recent CPI-W from the Bureau of Labor Statistics for the Philadelphia, Wilmington, and Atlantic City local area.

MHM Correctional Services
Delaware Substance Abuse Program
Summary Pricing Form
Contract Year One

Staff and Related Costs

Position	FTEs	Salaries & Benefits	Other Direct Staff Costs (1)	Total Staff Cost	Total Cost Per Hour
Assistant Program Manager	7.00	$417,036	$18,198	$435,233	$29.89
Clinical Supervisor	9.00	$470,333	$23,397	$493,730	$26.37
Counselor (Senior)	23.00	$937,490	$59,792	$997,283	$20.85
Counselor (Junior)	34.00	$1,172,606	$88,389	$1,260,995	$17.83
Admin Assistant	7.00	$292,641	$18,198	$310,838	$21.35
Region Admin Assistant	1.00	$49,508	$2,600	$52,108	$25.05
Case Manager	2.00	$99,016	$5,199	$104,215	$25.05
Program Manager	1.00	$78,117	$2,600	$80,717	$38.81
Regional Director	0.25	$30,805	$650	$31,455	$60.49
Total	84.25	$3,547,551	$219,022	$3,766,573	

Other Operating Costs (2)	**$50,000**
Facility, Regional, and Corporate Administrative	**$937,712**
Aggregate Total	**$4,754,285**
Number of Inmates	**8,105**
Per Offender Per Month	**$48.88**

(1) Other Direct Staff Costs include: payroll services, credentialing fees, cellular phone expense, malpractice insurance premiums, travel, relocation, training and drug testing.

(2) Other Operating Costs include clinical supplies and equipment.

(3) Local, Region, and Corporate Adminstrative includes (a) direct program expenses for copying and printing; postage and delivery; office supplies, equipment, and services; and performance bond; (b) Regional Office expenses including rent and other facility costs; and (c) Corporate Overhead, which includes, but is not limited to, costs for support functions for contract operations, clinical/quality assurance, recruiting, human resources, information technology, financial reporting, payroll, accounts receivable, accounts payable as well as costs for income taxes. A profit percentage of approximately 5% is included.

MHM Correctional Services
Delaware Substance Abuse Program
Detail Pricing Form By Facility
Contract Year One

Level V Programs

Position	FTEs	Salaries & Benefits	Other Direct Staff Costs (1)	Total Staff Cost	Total Cost Per Hour
Facility:	**Howard Young - Key North**				
Assistant Program Manager	1.00	$59,577	$2,600	$62,176	$29.89
Clinical Supervisor	2.00	$104,518	$5,199	$109,718	$26.37
Counselor (Senior)	3.00	$122,281	$7,799	$130,080	$20.85
Counselor (Junior)	6.00	$206,931	$15,598	$222,528	$17.83
Admin Assistant	1.00	$41,806	$2,600	$44,405	$21.35
Total Howard Young - Key North	13.00	$535,113	$33,796	$568,908	
Facility:	**Howard Young - 6 for 1 Program**				
Assistant Program Manager	1.00	$59,577	$2,600	$62,176	$29.89
Clinical Supervisor	0.00	$0	$0	$0	$0.00
Counselor (Senior)	2.00	$81,521	$5,199	$86,720	$20.85
Counselor (Junior)	2.00	$68,977	$5,199	$74,176	$17.83
Admin Assistant	0.30	$12,542	$780	$13,322	$21.35
Total Howard Young - 6 for 1	5.30	$222,616	$13,778	$236,394	
Facility:	**Howard Young - Criminal Offender Program**				
Assistant Program Manager	1.00	$59,577	$2,600	$62,176	$29.89
Clinical Supervisor	0.00	$0	$0	$0	$0.00
Counselor (Senior)	2.00	$81,521	$5,199	$86,720	$20.85
Counselor (Junior)	1.00	$34,488	$2,600	$37,088	$17.83
Admin Assistant	0.20	$8,361	$520	$8,881	$21.35
Total Howard Young - COP	4.20	$183,947	$10,919	$194,866	
Facility:	**Baylor - Women's Key Village**				
Assistant Program Manager	0.50	$29,788	$1,300	$31,088	$29.89
Clinical Supervisor	1.00	$52,259	$2,600	$54,859	$26.37
Counselor (Senior)	1.00	$40,760	$2,600	$43,360	$20.85
Counselor (Junior)	3.00	$103,465	$7,799	$111,264	$17.83
Admin Assistant	0.50	$20,903	$1,300	$22,203	$21.35
Total Baylor - Women's Key Village	6.00	$247,176	$15,598	$262,774	
Facility:	**Sussex - Key South**				
Assistant Program Manager	0.50	$29,788	$1,300	$31,088	$29.89
Clinical Supervisor	1.00	$52,259	$2,600	$54,859	$26.37
Counselor (Senior)	2.00	$81,521	$5,199	$86,720	$20.85
Counselor (Junior)	3.00	$103,465	$7,799	$111,264	$17.83
Admin Assistant	0.90	$37,625	$2,340	$39,965	$21.35
Total Sussex - Key South	7.40	$304,659	$19,238	$323,896	
Facility:	**Sussex Boot Camp**				
Assistant Program Manager	0.00	$0	$0	$0	$0.00
Clinical Supervisor	0.00	$0	$0	$0	$0.00
Counselor (Senior)	1.00	$40,760	$2,600	$43,360	$20.85
Counselor (Junior)	0.00	$0	$0	$0	$0.00
Admin Assistant	0.10	$4,181	$260	$4,441	$21.35
Total Sussex - Boot Camp	1.10	$44,941	$2,860	$47,801	
Facility:	**Regional Office**				
Region Admin Assistant	1.00	$49,508	$2,600	$52,108	$25.05
Case Manager	2.00	$99,016	$5,199	$104,215	$25.05
Program Manager	1.00	$78,117	$2,600	$80,717	$38.81
Regional Director	0.25	$30,805	$650	$31,455	$60.49
Total Regional Office	4.00	$226,641	$10,399	$237,039	

Level IV Programs

Position	FTEs	Salaries & Benefits	Other Direct Staff Costs	Total Staff Cost	Total Cost Per Hour
Facility:	**Plummer - Crest**				
Assistant Program Manager	0.70	$41,704	$1,820	$43,523	$29.89
Clinical Supervisor	0.70	$36,581	$1,820	$38,401	$26.37
Counselor (Senior)	2.00	$81,521	$5,199	$86,720	$20.85
Counselor (Junior)	4.00	$137,954	$10,399	$148,352	$17.83
Admin Assistant	0.70	$29,264	$1,820	$31,084	$21.35
Total Plummer - Crest	8.10	$327,024	$21,057	$348,081	
Facility:	**Plummer - Aftercare**				
Assistant Program Manager	0.30	$17,873	$780	$18,653	$29.89
Clinical Supervisor	0.30	$15,678	$780	$16,458	$26.37
Counselor (Senior)	1.00	$40,760	$2,600	$43,360	$20.85
Counselor (Junior)	2.00	$68,977	$5,199	$74,176	$17.83
Admin Assistant	0.30	$12,542	$780	$13,322	$21.35
Total Plumber - Aftercare	3.90	$155,830	$10,139	$165,968	
Facility:	**Women's TX TC - Crest**				
Assistant Program Manager	0.30	$17,873	$780	$18,653	$29.89
Clinical Supervisor	0.70	$36,581	$1,820	$38,401	$26.37
Counselor (Senior)	2.00	$81,521	$5,199	$86,720	$20.85
Counselor (Junior)	2.00	$68,977	$5,199	$74,176	$17.83
Admin Assistant	0.80	$33,445	$2,080	$35,524	$21.35
Total Women's Crest	5.80	$238,397	$15,078	$253,475	
Facility:	**Women's TX TC - Aftercare**				
Assistant Program Manager	0.20	$11,915	$520	$12,435	$29.89
Clinical Supervisor	0.30	$15,678	$780	$16,458	$26.37
Counselor (Senior)	1.00	$40,760	$2,600	$43,360	$20.85
Counselor (Junior)	1.00	$34,488	$2,600	$37,088	$17.83
Admin Assistant	0.20	$8,361	$520	$8,881	$21.35
Total Women's Aftercare	2.70	$111,203	$7,019	$118,222	
Facility:	**Morris - Crest**				
Assistant Program Manager	0.70	$41,704	$1,820	$43,523	$29.89
Clinical Supervisor	1.50	$78,389	$3,899	$82,288	$26.37
Counselor (Senior)	2.00	$81,521	$5,199	$86,720	$20.85
Counselor (Junior)	5.00	$172,442	$12,998	$185,440	$17.83
Admin Assistant	0.80	$33,445	$2,080	$35,524	$21.35
Total Morris - Crest	10.00	$407,500	$25,997	$433,497	
Facility:	**Morris - Aftercare**				
Assistant Program Manager	0.30	$17,873	$780	$18,653	$29.89
Clinical Supervisor	0.50	$26,130	$1,300	$27,429	$26.37
Counselor (Senior)	1.00	$40,760	$2,600	$43,360	$20.85
Counselor (Junior)	1.00	$34,488	$2,600	$37,088	$17.83
Admin Assistant	0.20	$8,361	$520	$8,881	$21.35
Total Morris - Aftercare	3.00	$127,613	$7,799	$135,412	
Facility:	**Sussex - Crest**				
Assistant Program Manager	0.30	$17,873	$780	$18,653	$29.89
Clinical Supervisor	0.70	$36,581	$1,820	$38,401	$26.37
Counselor (Senior)	2.00	$81,521	$5,199	$86,720	$20.85
Counselor (Junior)	3.00	$103,465	$7,799	$111,264	$17.83
Admin Assistant	0.70	$29,264	$1,820	$31,084	$21.35
Total Sussex - Crest	6.70	$268,705	$17,418	$286,122	
Facility:	**Sussex - Aftercare**				
Program Director	0.20	$11,915	$520	$12,435	$29.89
Clinical Supervisor	0.30	$15,678	$780	$16,458	$26.37
Counselor (Senior)	1.00	$40,760	$2,600	$43,360	$20.85
Counselor (Junior)	1.00	$34,488	$2,600	$37,088	$17.83
Admin Assistant	0.30	$12,542	$780	$13,322	$21.35
Total Sussex CI, WR, & VOP	2.80	$115,384	$7,279	$122,663	

(1) Other Direct Staff Costs include: payroll services, credentialing fees, cellular phone expense, malpractice insurance premiums, travel, relocation, training and drug testing.

ATTACHMENTS

Table of Contents

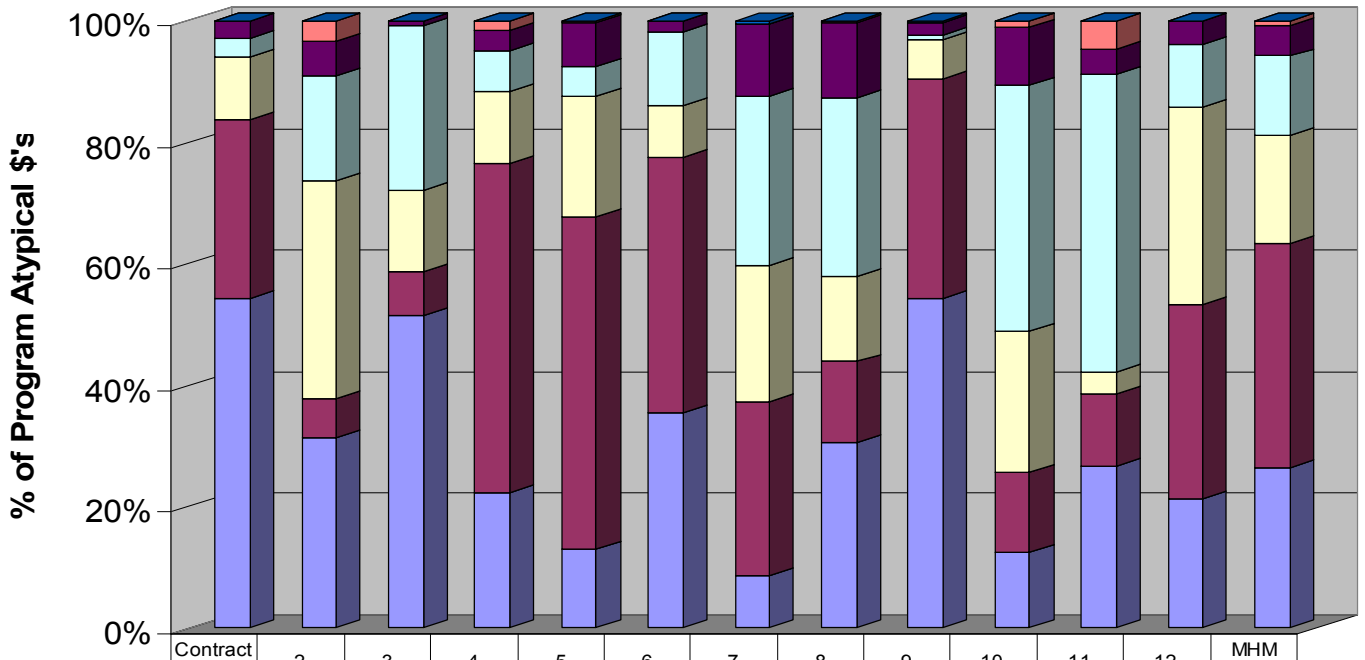
Abbreviated Pharmacy Monthly Reporting Package
2008

MHM Services, Inc

MHM Services, Inc

Monthly Highlights – Atypical Snapshot

Atypical Brand Monthly Costs as % of Total Atypical Costs



	Contract 1	2	3	4	5	6	7	8	9	10	11	12	MHM Total
Invega	$-	$-	$-	$387	$214	$-	$147	$-	$306	$-	$-	$-	$1,053
Clozaril	$-	$2,723	$-	$4,281	$532	$88	$-	$38	$-	$1,171	$3,726	$-	$12,559
Abilify	$2,191	$4,506	$268	$9,699	$20,919	$1,262	$3,130	$2,180	$2,849	$10,535	$3,479	$7,987	$69,006
Zyprexa	$2,352	$13,527	$9,795	$19,348	$13,736	$8,897	$7,361	$5,144	$1,020	$44,075	$39,364	$20,148	$184,76
Seroquel	$7,854	$28,134	$4,872	$35,045	$56,088	$6,390	$5,969	$2,449	$8,999	$25,159	$2,947	$64,400	$248,30
Geodon	$22,403	$4,957	$2,605	$157,01	$155,70	$30,981	$7,512	$2,315	$48,905	$14,398	$9,534	$63,531	$519,86
Risperdal	$41,409	$24,600	$18,598	$64,889	$36,715	$26,178	$2,294	$5,334	$73,354	$13,572	$21,455	$42,155	$370,55

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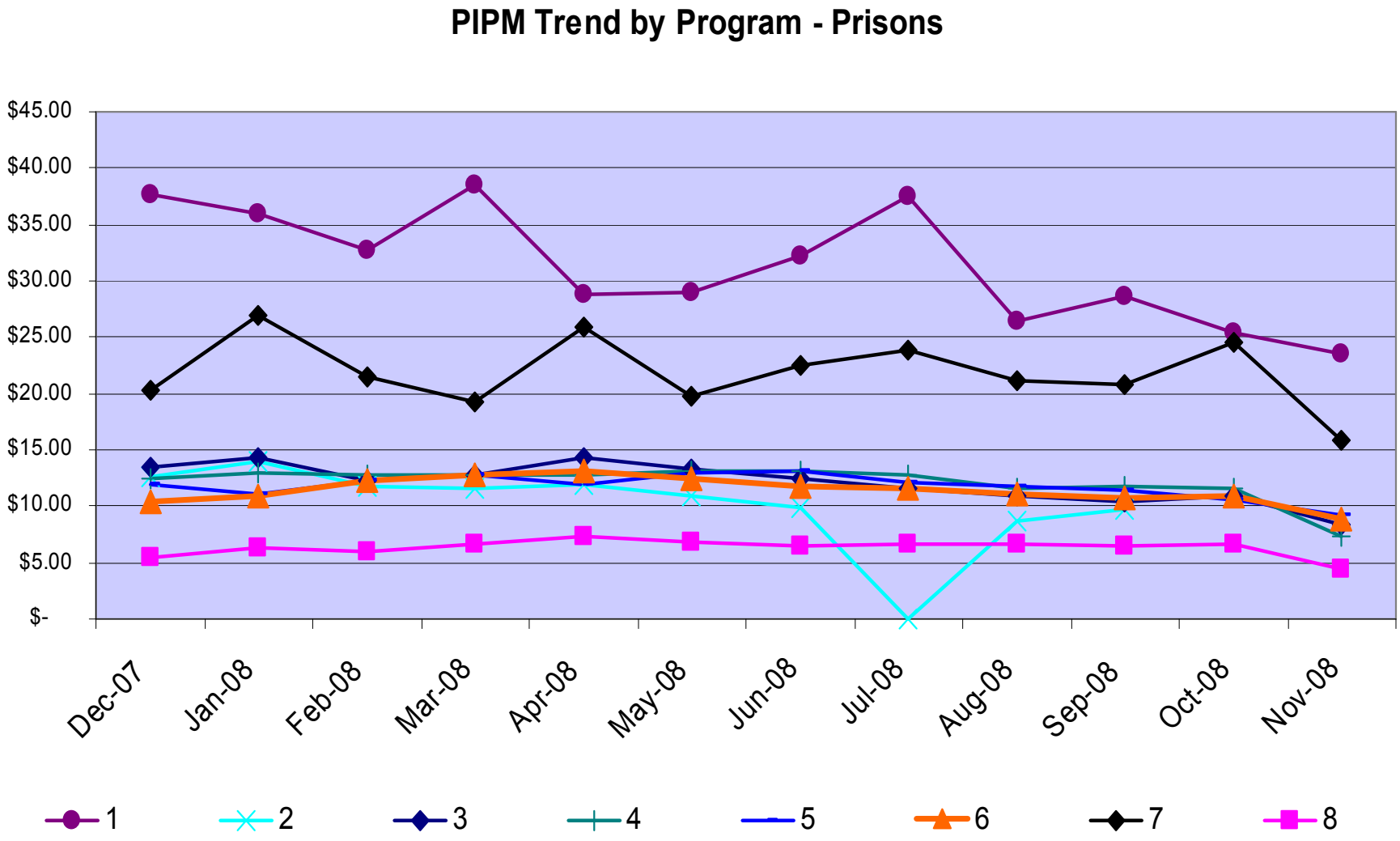
PIPM Trend by Program - Prisons
$45.00
$40.00
$35.00
$30.00
$25.00
$20.00
$15.00
$10.00
$5.00
$-
Dec-07
Jan-08
Feb-08
Mar-08
Apr-08
May-08
Jun-08
Jul-08
Aug-08
Sep-08
Oct-08
Nov-08
1
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PHARMACY MONTHLY CONTRACT REPORT

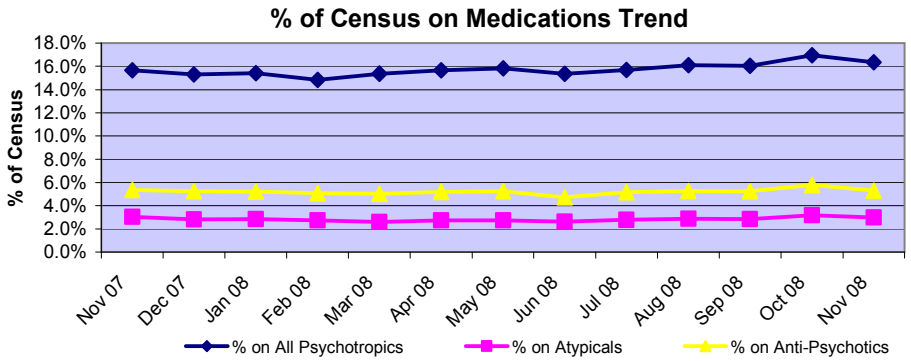
December 2008

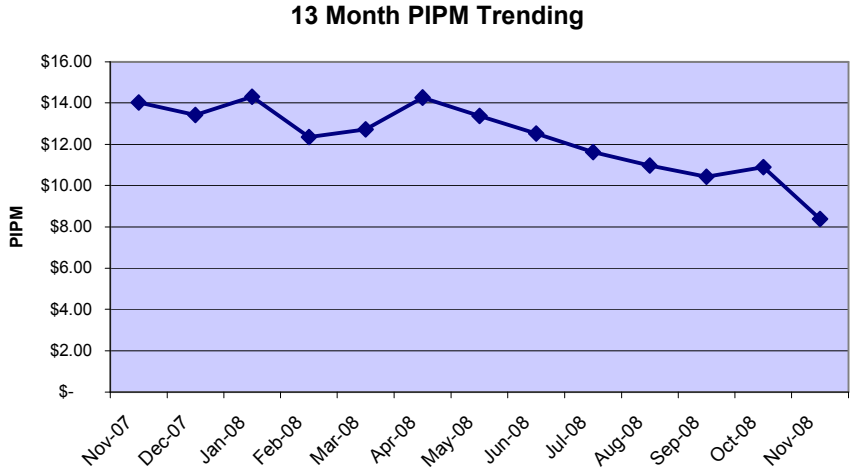
Rx = Prescriptions

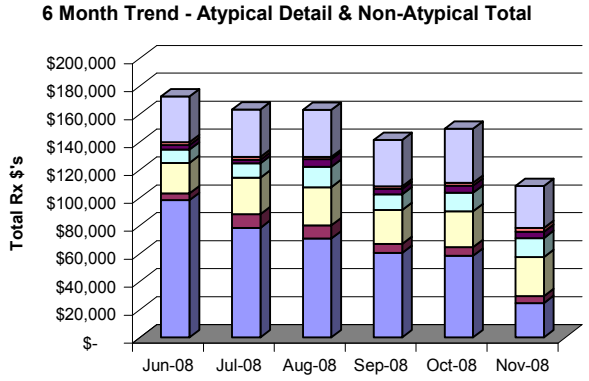
	Program	Rx Cost	Census	# on Rx	% on Rx	PIPM	# Rxs	Cost/Rx	Avg # Rx	Cst /InmOnRx
State Prisons	1	$ 96,616	25,396	1,835	7.2%	$ 3.80	4,779	$ 20.22	2.60	$ 52.65
	2	$ 102,438	14,056	2,432	17.3%	$ 7.29	6,958	$ 14.72	2.86	$ 42.12
	3	$ 187,271	10,952	2,153	19.7%	$ 17.10	7,452	$ 25.13	3.46	$ 86.98
	4	$ 303,427	30,449	5,666	18.6%	$ 9.97	5,441	$ 55.77	0.96	$ 53.55
	5	$ 428,268	47,383	5,614	11.8%	$ 9.04	19,650	$ 21.79	3.50	$ 76.29
	6	$ 205,291	18,151	2,495	13.7%	$ 11.31	5,426	$ 37.83	2.17	$ 82.28
	7	$ 405,256	47,968	9,037	18.8%	$ 8.45	11,051	$ 36.67	1.22	$ 44.84
	8	$ 233,960	26,484	4,690	17.7%	$ 8.83	10,684	$ 21.90	2.28	$ 49.88
	9	$ 36,083	1,550	549	35.4%	$ 23.28	1,608	$ 22.44	2.93	$ 65.73
Jails	10	$ 39,793	3,337	261	7.8%	$ 11.93	486	$ 81.88	1.86	$ 152.46
	11	$ 76,752	8,829	1,775	20.1%	$ 8.69	4,343	$ 17.67	2.45	$ 43.24
	12	$ 36,438	2,065	375	18.2%	$ 17.65	1,266	$ 28.78	3.38	$ 97.17

Contract 1 Monthly Dashboard

	Current Month	Prior Month	Var: Fav / (Unfav) $	Var: Fav / (Unfav) %
Monthly Rx Cost:	$ 117,655	$ 152,999	$ 35,345	23%
Current Month # of Rx:	5,947	6,943	996	14%
Census	14,057	14,058	1	0%
# of Inmates on Psychotropic Meds	2,299	2,384	85	4%
# of Inmates on Anti-Psychotic Mec	745	814	69	8%
# of Inmates on Atypical Meds	418	446	28	6%







	Jun	Jul	Aug	Sep	Oct	Nov
Non-Atypical & Credits	$32,788	$33,884	$33,689	$33,278	$38,724	$30,026
Invega						
Clozaril	$1,940	$2,128	$1,778	$1,710	$2,016	$2,723
Abilify	$3,319	$2,529	$5,362	$4,031	$4,955	$4,506
Zyprexa	$9,380	$10,376	$14,493	$11,300	$13,412	$13,527
Seroquel	$21,994	$26,112	$27,420	$24,183	$25,560	$28,134
Geodon	$4,777	$9,749	$9,442	$6,478	$6,297	$4,957
Risperdal	$98,359	$78,511	$70,802	$60,526	$58,428	$24,600

	Jun	Jul	Aug	Sep	Oct	Nov
Atypical Totals	$139,768	$129,404	$129,295	$108,227	$110,668	$78,448

Contract 1 Program Detailed Report

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Rx Costs	188,988	173,485	177,107	196,493	188,110	172,557	163,289	162,984	141,506	149,391	108,474
Admin Fees	21,716	19,525	20,629	22,120	22,359	21,178	22,766	23,420	21,748	25,323	21,740
Returns	10,052	19,056	17,901	17,045	21,066	16,348	21,497	31,890	16,612	21,715	12,559
Total Rx Costs	200,651	173,954	179,835	201,569	189,403	177,386	164,558	154,515	146,641	152,999	117,655
Census	14,033	14,085	14,139	14,138	14,164	14,172	14,147	14,101	14,052	14,058	14,057
Caseload/Encounters	1,694	1,798	1,499	1,687	1,771	1,852	1,629	1,829	2,008	2,174	2,004
Caseload as % of census	12%	13%	11%	12%	13%	13%	12%	13%	14%	15%	14%
# on Rx	2,164	2,090	2,174	2,214	2,244	2,175	2,217	2,268	2,254	2,384	2,299
# on Rx as % of Census	15.4%	14.8%	15.4%	15.7%	15.8%	15.3%	15.7%	16.1%	16.0%	17.0%	16.4%
# on anti-psychotics	732	716	709	734	740	670	732	745	740	814	745
# on Atypicals	*400*	*387*	*368*	*388*	*387*	*371*	*393*	*403*	*401*	*446*	*418*
# on Typicals	*351*	*350*	*364*	*372*	*382*	*326*	*367*	*375*	*365*	*395*	*359*
# on anti-depressants	1,660	1,610	1,649	1,711	1,739	1,697	1,723	1,742	1,723	1,845	1,754
# on 1st Gen	*878*	*878*	*902*	*924*	*893*	*894*	*889*	*917*	*893*	*963*	*879*
# on 2nd Gen (SSRI)	*1,049*	*1,000*	*1,001*	*1,056*	*1,086*	*1,075*	*1,096*	*1,096*	*1,053*	*1,113*	*1,067*
# scripts filled	5,944	5,354	5,666	6,053	6,135	5,793	6,240	6,409	5,939	6,943	5,947
Cost per inmate on Rx	$ 92.72	$ 83.23	$ 82.72	$ 91.04	$ 84.40	$ 81.56	$ 74.23	$ 68.13	$ 65.06	$ 64.18	$ 51.18
g. # scripts per inmate on Rx	2.75	2.56	2.61	2.73	2.73	2.66	2.81	2.83	2.63	2.91	2.59
PIPM	$ 14.30	$ 12.35	$ 12.72	$ 14.26	$ 13.37	$ 12.52	$ 11.63	$ 10.96	$ 10.44	$ 10.88	$ 8.37
avg. cost per script	$ 33.76	$ 32.49	$ 31.74	$ 33.30	$ 30.87	$ 30.62	$ 26.37	$ 24.11	$ 24.69	$ 22.04	$ 19.78

DOC PSYCHATRIST MEETING
February, 2009

Gregg Puffenberger, PharmD, MBA
Director of Pharmacy Management
MHM Services Inc

The Evolution of Dosing Patterns of 1st Generation Antipsychotics

- There are a number of articles published in the 70's and 80's documenting that researchers at the time believed FGA doses used in clinical practice were too high—pts were being exposed to potentially toxic doses without additional clinical benefit
- A number of review articles were published that calculated average doses in use
- Today, we will compare the average dose of various FGAs in use in the PA DOC to the average doses in use during the mid 80's

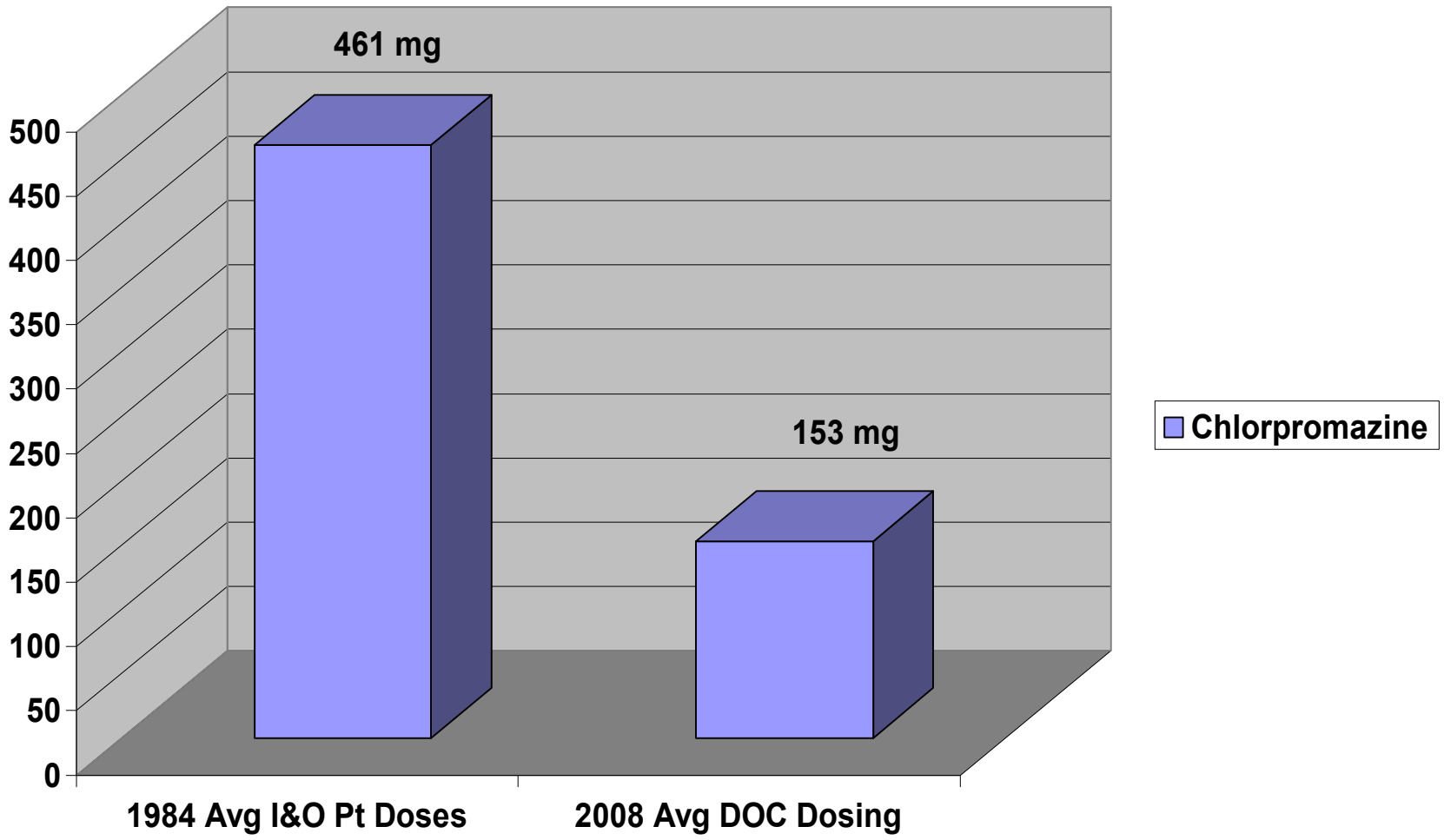
Baldessarini, RJ et al. Dissimilar Dosing with High Potency and Low Potency Neuroleptics. Am J Psychiatry 1984; 141:748-752

The Evolution of Dosing Patterns of 1st Generation Antipsychotics

- The 1984 dataset for the comparison consists of records 110 inpatients in a Boston psychiatric hospital & 16,000 Veterans Affairs patients
- The modern dataset was derived from pharmacy data from the PA DOC for 1200 patients on FGAs during Oct-Dec 2008

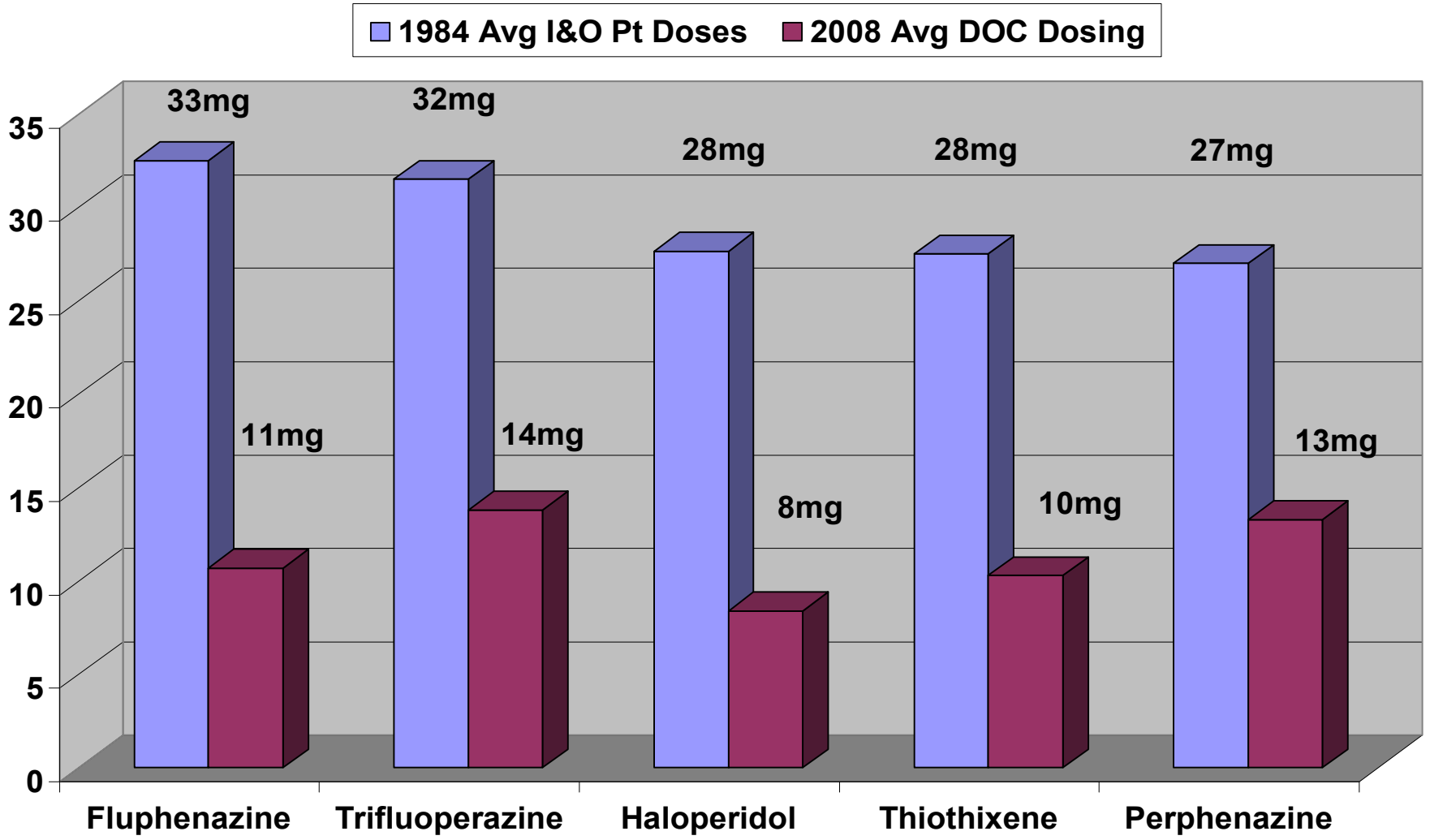
Baldessarini, RJ et al. Dissimilar Dosing with High Potency and Low Potency Neuroleptics. Am J Psychiatry 1984; 141:748-752

Chlorpromazine Dosing Evolution
Baldessarini, R et al. Dissimilar Dosing With High Potency and Low Potency Neuroleptics. Am J Psychiatry 1984; 141: 748- 752



Comparison 1984 vs 2008 Avg In and Outpatient Doses

Baldessarini, R et al. Dissimilar Dosing With High Potency and Low Potency Neuroleptics. Am J Psychiatry 1984; 141: 748- 752



Average Percent of Doses dispensed over last 6 months

	MASS	MO	GDOC	ADOC	AVG.	FDOC	MD	TDOC	Philly	PA
Cost / Inmate	$111	?	$98	$85		$82	$75	$69	$68	$62
Risperdal	34%	30%	42%	69%		69%	89%	63%	58%	52%
Geodon	10%	18%	41%	21%		23%	6%	7%	34%	23%
Seroquel	26%	41%	11%	4%		5%	1%	15%	7%	3%
Zyprexa	20%	8%	2%	3%		1%	2%	4%	0%	3%
Abilify	3%	2%	3%	1%		1%	0%	1%	1%	2%
Clozaril	8%	0%	1%	3%		1%	1%	10%	0%	8%
Atypical Total	78%	54%	57%	49%	51%	54%	43%	45%	35%	51%
Typical Total	22%	46%	43%	51%	49%	46%	57%	55%	74%	49%

Common FGA Side Effects

Adapted from CNS Special Edition, Dec 2002, CATIE Phase I, TEOSS

Drug	Anticholinergic	EPS	Hypotension	Prolactin Elevation	QTc Prolongation	Sedation
Chlorpromazine	+++	++	+++	+	+	+++
Fluphenazine	+	++++	+	++	0	+
Perphenazine	+	++	+	+	+	+
Trifluoperazine	+	++++	+	++	+	+
Haloperidol	0	++++	0	++++	0	+
Loxapine	+	+++	+	++	+	+
Molindone	+	++	+	+	+	+
Thiothixene	+	++	+	++	+	+

EPS Differences between Low Potency FGAs and SGAs

Leucht, S. New Generation Antipsychotics vs Low Potency Conventional Antipsychotics: A Systematic Review and Meta Analysis. Lancet 2003; 361: 1581-1589

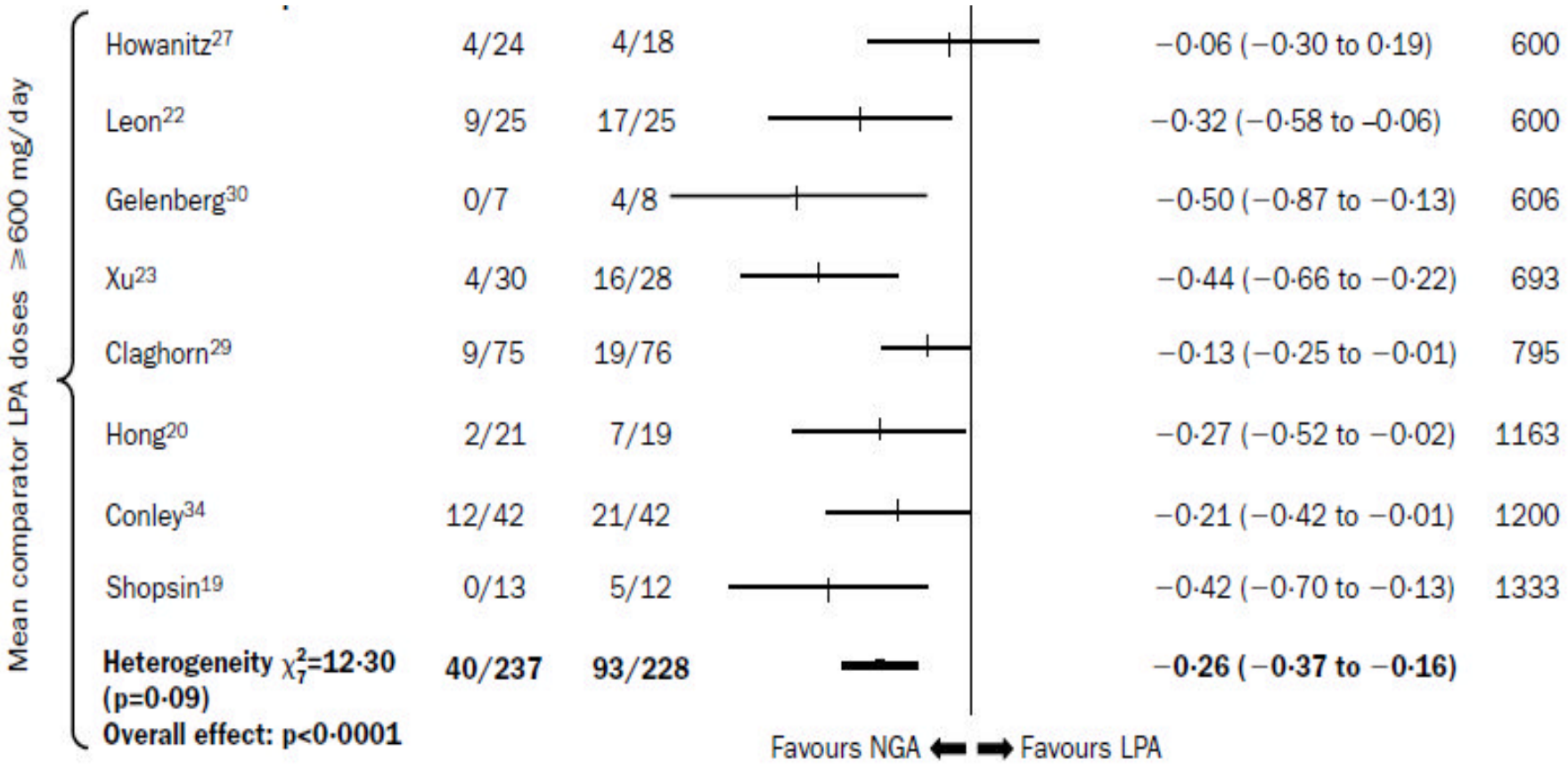


Figure 1: **Risk difference between groups for EPS**

NGA=new generation antipsychotic. LPA=low-potency conventional antipsychotic. n=number of patients with at least one EPS. N=number of patients in group.

Efficacy Differences Between Low Potency FGA and SGAs

Leucht, S. New Generation Antipsychotics vs Low Potency Conventional Antipsychotics: A Systematic Review and Meta Analysis. Lancet 2003; 361: 1581-1589

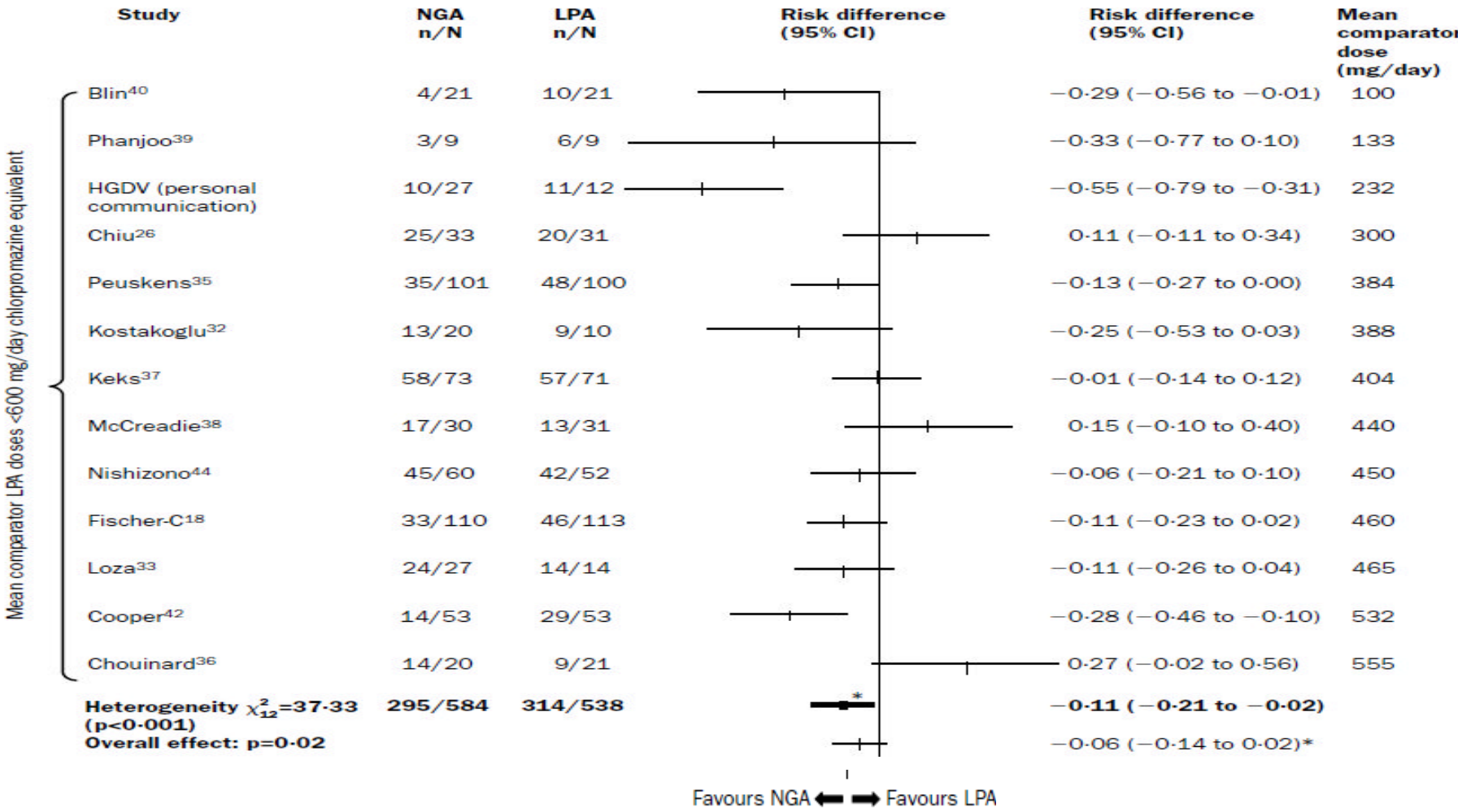
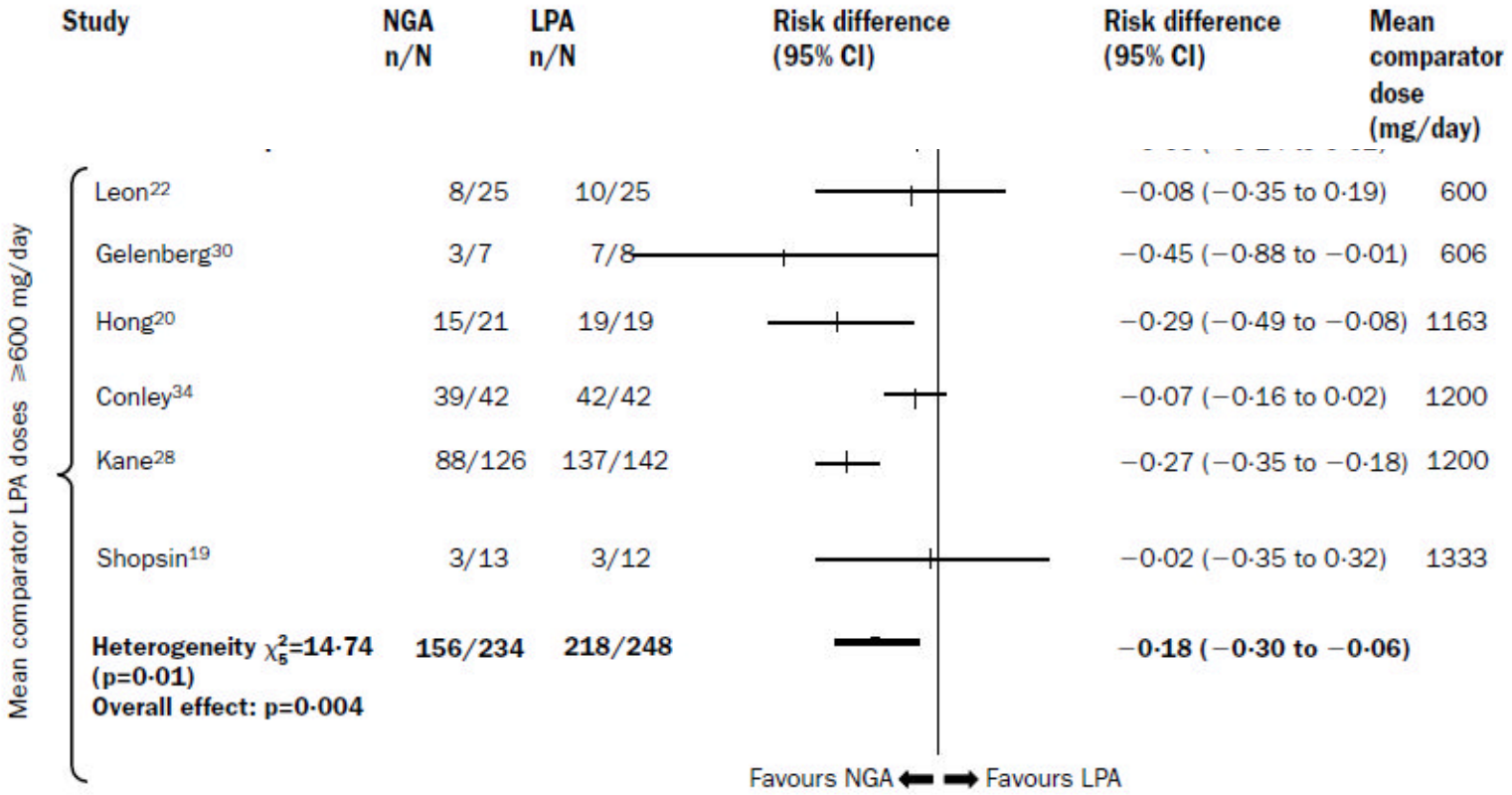


Figure 2: **Efficacy analysis: number of patients with no clinically significant response**

*Pooled RD after studies with comparator doses lower than 300 mg/day of chlorpromazine equivalent were excluded. NGA=new generation antipsychotic. LPA=low-potency conventional antipsychotic. n=number of patients with at least one EPS. N=number of patients in group.

Efficacy Differences Between Low Potency Antipsychotics and SGAs

Leucht, S. New Generation Antipsychotics vs Low Potency Conventional Antipsychotics: A Systematic Review and Meta Analysis. Lancet 2003; 361: 1581-1589



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*Pooled RD after studies with comparator doses lower than 300 mg/day of chlorpromazine equivalent were excluded. NGA=new generation antipsychotic. LPA=low-potency conventional antipsychotic. n=number of patients with at least one EPS. N=number of patients in group.

Do SGAs Pay for Themselves?

- A database of 37,369 individuals diagnosed with schizophrenia at some point from 1993 - 2001 in the California Medicaid database
- The timeframe allows analysis of a time when no patients took SGAs to a time when 70% were taking them
- The analysis was exploratory to find out if SGAs decreased inpatient costs, decreased side effects such as EPS and TD, and to look for changes in claims related to metabolic SEs

Duggan, M. Do New Prescription Drugs Pay For Themselves? The Case of Second Generation Antipsychotics. J Health Economics. 2005 24: 1-31

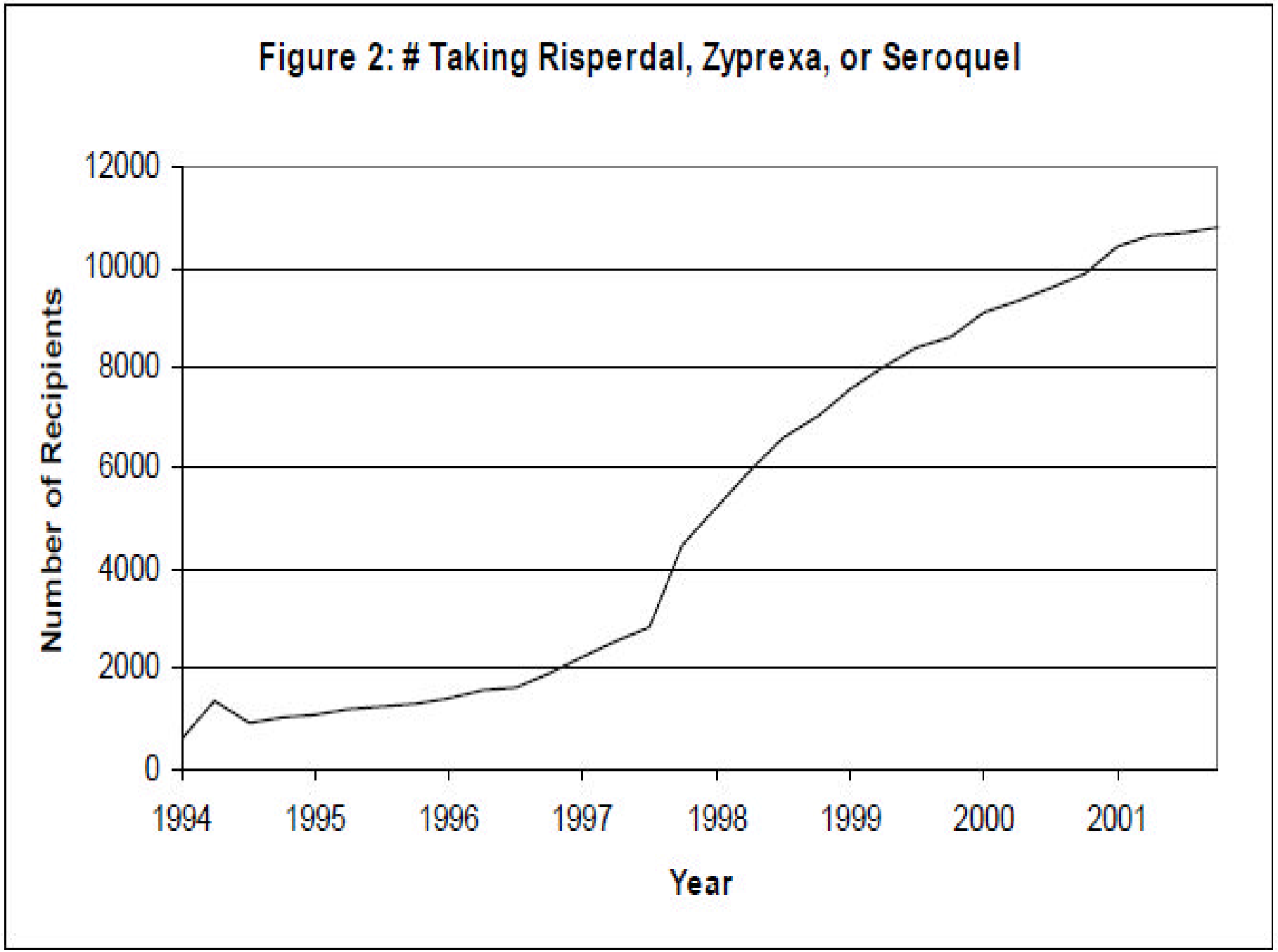


Figure 2: # Taking Risperdal, Zyprexa, or Seroquel
12000
10000
8000
6000
4000
2000
0
Number of Recipients
1994
1995
1996
1997
1998
1999
2000
2001
Year

Trends in Side Effects nd Healthcare Utilization During the transition to SGAs in the Late 1990s
Trends in Spending, Utilization, and Health Outcomes for Medicaid Recipients with Schizophrenia

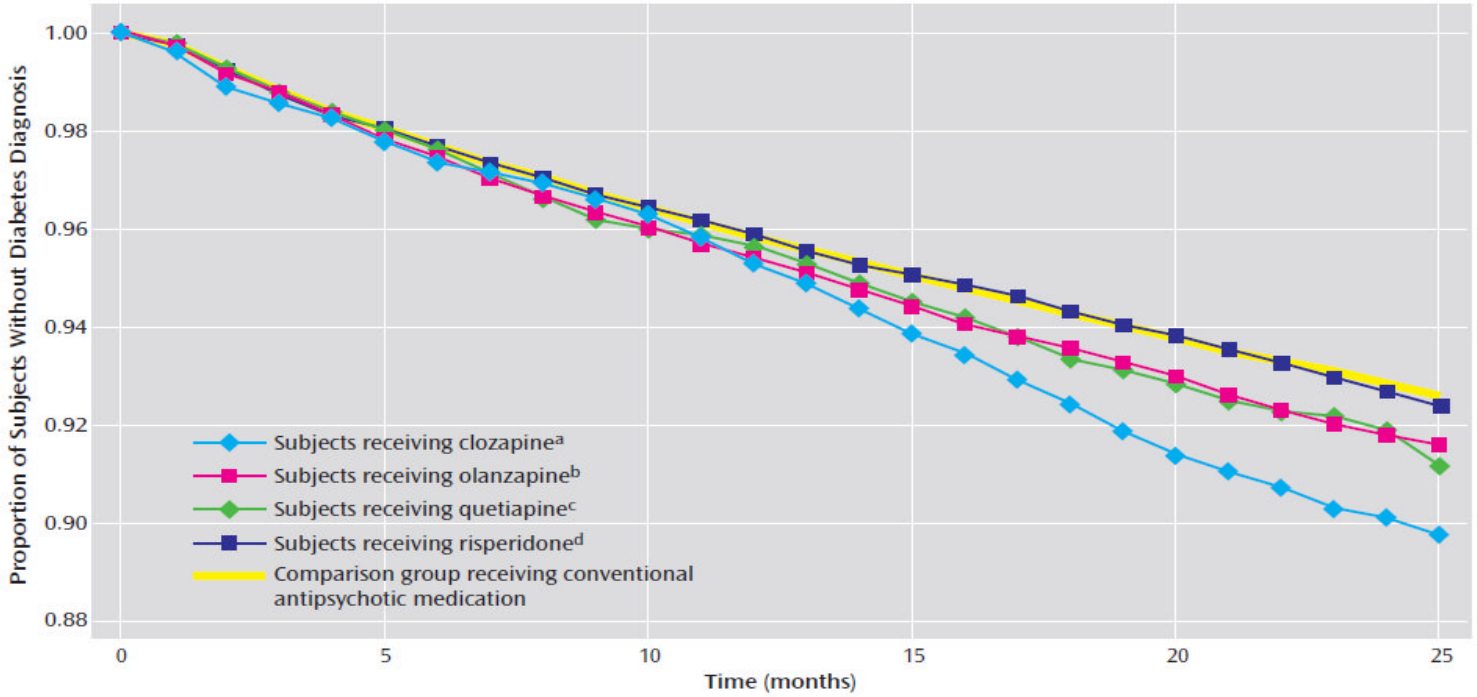
	1993	1994	1995	1996	1997	1998	1999	2000	2001
Average Age	43.5	42.9	42.7	43.4	43.8	43.9	44.1	44.2	44.4
% Male	53.4	54.6	55.1	55.1	54.9	55.7	56.2	56.6	56.5
Avg Antipsyc Rx Paid	**586**	791	893	937	**1174**	1867	2294	2562	**2854**
Avg Other Rx Paid	671	686	654	775	925	1070	1259	1491	1760
Avg Medicaid Expenditures	9304	9892	9215	9502	**9895**	11182	12326	12714	**14103**
% Risperdal	**0%**	13%	12.30%	14.10%	**17.20%**	22.80%	25.80%	30.40%	**32.80%**
% Zyprexa	**0%**	0%	0%	1.90%	**15.80%**	32.70%	36.60%	39.10%	**39.90%**
% Seroquel	**0%**	0%	0%	0%	**0.30%**	4.90%	9.40%	13%	**17.10%**
% any RZS	0%	13.00%	12.30%	15.10%	29.30%	49.70%	58.10%	64.70%	69%
% Other Antipsychotics	76.70%	81.70%	78.10%	76.50%	72.90%	66.60%	60.10%	54.60%	49.10%
% Any Antipsychotic	76.70%	83.20%	81.10%	80.70%	81.60%	84.90%	86.20%	87.10%	86.70%
Any Hospitalization	32.40%	34%	34.10%	33.90%	32.60%	33.50%	34.20%	34.70%	34.50%
Avg Hospital Days	**6.7**	7.5	7.4	7.2	**7.3**	7.4	7.5	7.7	**7.9**
% Any Diabetes	**7.29%**	5.92%	6.62%	7.51%	**8.30%**	8.30%	8.99%	9.87%	**10.86%**
% Any Hyperlipedemia	**3.69%**	2.91%	3.57%	5.17%	**5.80%**	5.10%	5.42%	6.61%	**7.24%**
% Any Abnormal wt, OBESE	**2.11%**	1.55%	1.64%	1.09%	**1.60%**	1.49%	1.76%	1.85%	**1.73%**
% Tardive Dyskenesia	**0.65**	0.71	0.80	1.27	**1.07**	0.53	0.44	0.48	**0.43**
% Any Parkinsonian Symptoms	**0.81**	0.48	0.47	0.60	**0.71**	0.41	0.61	0.51	**0.63**
% other EPS	**0.83**	0.74	0.74	1.07	**0.87**	0.69	0.65	0.65	**0.69**
Number of Observations	12741	12114	12333	13578	14081	13329	13186	13481	14083

Duggan, M. Do New Prescription Drugs Pay For Themselves? The Case of Second Generation Antipsychotics. J Health Economics. 2005 24: 1-31

FGAs & SGAs & Diabetes in the VA System n=57,000

Leslie, D et al. Incidence of Newly Diagnosed Diabetes Attributable to Atypical Antipsychotic Medications. Am J Psychiatry; 2004; 161:1709- 1711

FIGURE 1. Fitted Survival Functions From the Cox Proportional Hazards Model Predicting Time to Diabetes Mellitus Onset Among Outpatients With Schizophrenia For Whom a Stable Regimen of Antipsychotic Monotherapy Was Prescribed

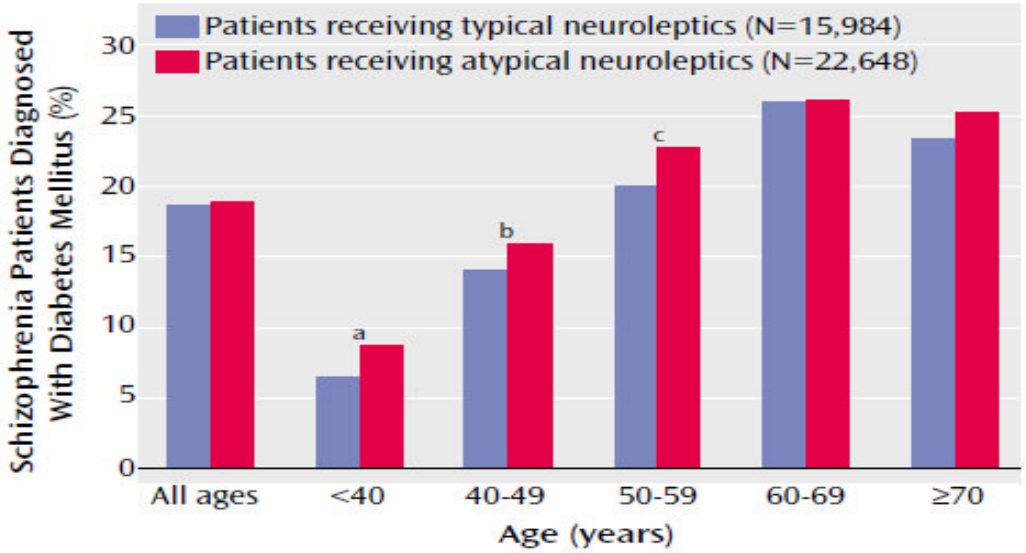


[a] Hazard ratio=1.57, 95% confidence interval (CI)=1.31–1.89
[b] Hazard ratio=1.15, 95% CI=1.07–1.24
[c] Hazard ratio=1.20, 95% CI=0.99–1.44
[d] Hazard ratio=1.01, 95% CI=0.93–1.10

FGAs & SGAs & Diabetes in the VA System
n=38,000

Sernyak, M et al. Association of Diabetes Mellitus With the Use of Atypical Neuroleptics in the Treatment of Schizophrenia. Am J Psychiatry 2002; 159: 561- 566

FIGURE 1. Percentage of Patients With Schizophrenia Receiving Prescriptions for Atypical and Typical Neuroleptic Medication Who Also Had a Diagnosis of Diabetes Mellitus

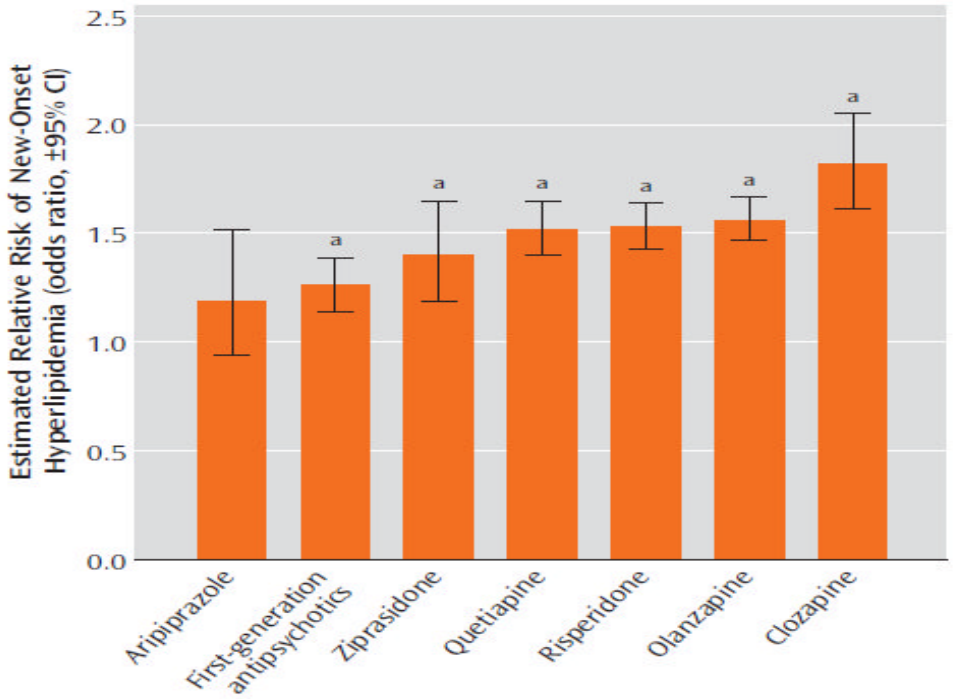


[a] $\chi^2=7.24$, df=1, $p<0.07$.
[b] $\chi^2=9.81$, df=1, $p=0.002$.
[c] $\chi^2=8.53$, df=1, $p=0.003$.

SGAs & FGAs and Hyperlipidemia in the CA Medicaid System (13,000)

Olfson, M et al. Hyperlipidemia Following Treatment With Antipsychotic Medicatication. Am J Psychiatry 2006; 163: 1821- 1825

FIGURE 1. Association of Antipsychotic Medication Treatment With New-Onset Hyperlipidemia in Adults With Psychotic Disorders



[a] Significantly different from no antipsychotic medication treatment (reference), $p<.0.05$.

What differences exist between FGAs and SGAs with respect to Tardive Dyskinesia?

Correll, C. Tardive dyskinesia and new antipsychotics. Current Opinion in Psychiatry 2008; 21: 151-156

	All 12	6 Head to head	Elderly	**(-)Perph CATIE**	**(-) all CATIE**	Adults (-) Perph CATIE	Adults (-)All CATIE	**Children**	All Adults
SGA	3.95	4.2	5.2	3.95	3.17	2.98	1.16	0.35	2.98
FGA	5.5	5.5	5.2	5.08	5.08	3.9	3.9	nd	7.7
Diff	1.55	1.3	0	1.13	1.91	0.92	2.74	nd	4.72

What differences exist between FGAs and SGAs with respect to Tardive Dyskinesia?

Correll, C. Tardive dyskinesia and new antipsychotics. Current Opinion in Psychiatry 2008; 21: 151-156

	n	Mean age	% Male	% White	% Dx SCZ
SGA	15,127	35.7	65.4	71.9	30
FGA	12,924	51.1	43.4	65.5	6

What differences exist between FGAs and SGAs with respect to EPS or Tardive Dyskinesia?

Table 3. Outcome Measures of Safety among Randomized Patients.

Outcome	Olanzapine (N=336)	Quetiapine (N=337)	Risperidone (N=341)	Perphenazine (N=261)*	Ziprasidone (N=185)	P Value†
Neurologic effects — no./total no. (%)§						
AIMS global severity score ≥2	32/236 (14)	30/236 (13)	38/238 (16)	41/237 (17)	18/126 (14)	0.23
Barnes Akathisia Rating Scale global score ≥3	15/290 (5)	16/305 (5)	20/292 (7)	16/241 (7)	14/158 (9)	0.24
Simpson–Angus Extrapyramidal Signs Scale mean score ≥1	23/296 (8)	12/298 (4)	23/292 (8)	15/243 (6)	6/152 (4)	0.47

§ Scores of 2 or more on the Abnormal Involuntary Movement Scale (AIMS) global severity score indicate at least mild severity of abnormal movements. Percentages are based on the number of patients without tardive dyskinesia who had an AIMS score of less than 2 at baseline and at least one post-baseline measurement. Scores of 3 or more for the global clinical assessment of the Barnes Akathisia Rating Scale indicate at least moderate severity of akathisia. Percentages are based on the number of patients who had a Barnes score of less than 3 at baseline and at least one post-baseline measurement. Average scores of 1 or more for the Simpson–Angus Extrapyramidal Signs Scale indicate at least mild severity of extrapyramidal signs. Percentages are based on the number of patients who had an average score for the Simpson–Angus Extrapyramidal Signs Scale of less than 1 at baseline and at least one post-baseline measurement.

TD in an Elderly Population

Lee, P et al. Antipsychotic Medications and Drug-Induced Movement Disorders Other Than Parkinsonism: A Population-Based Cohort Study in Older Adults. JAGS 2005; 53: 1374-1379

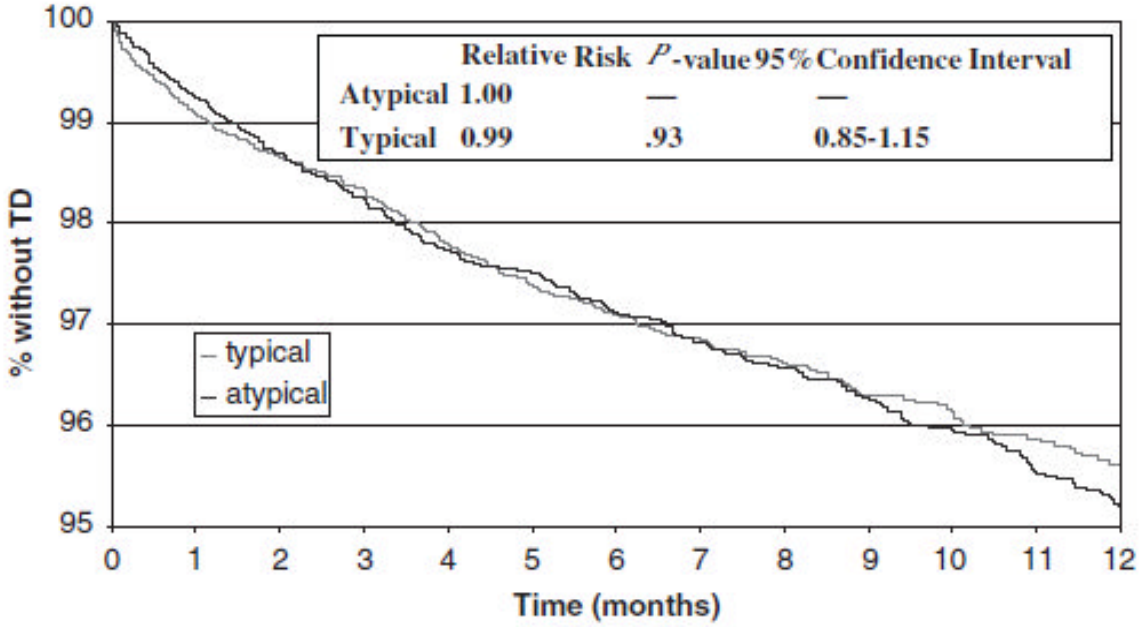


Figure 1. Cox proportional hazards for the percentage of patients without drug-induced movement disorders.

What differences exist between FGAs and SGAs with respect to EPS or Tardive Dyskenisa?

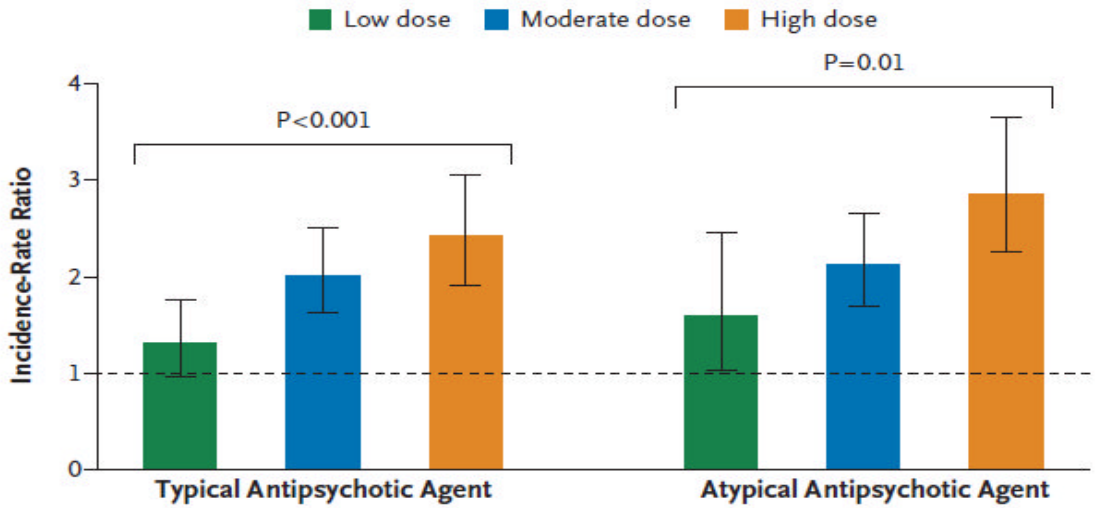
- Several meta analyses have attempted to address this issue
- There are no well designed studies that offer definitive answers for both EPS and TD for all FGAs
- The differences between published EPS or TD rates of FGAs & SGAs are often misleading in that Haloperidol is the most widely used comparator and the severity of TD is often not addressed
- Data on low and medium potency FGAs is needed

The Risk of Sudden Cardiac Death and Antispychotics

- The authors calculated the adjusted incidence of sudden cardiac death among users of antipsychotics
- Tennessee Medicaid database sample of 44,218 and 46,089 users of typical or atypical antipsychotics and 186,600 non users as a control (former users are analyzed as well)
- The drugs included were haloperidol, thioridazine, clozapine, risperidone, olanzapine, and quetiapine

Wayne, RA et al. Atypical Antipsychotic Drugs and the Risk of Sudden Cardiac Death.
N Engl J Med 2009; 360: 225-235

The Risk of Sudden Cardiac Death and Antipsychotics



No. of Deaths	46	104	105	22	108	93
No. of Person-Years	21,438	33,671	31,626	10,435	41,513	27,641
Incidence-Rate Ratio	1.31	2.01	2.42	1.59	2.13	2.86
95% CI	0.97–1.77	1.62–2.50	1.91–3.06	1.03–2.46	1.70–2.65	2.25–3.65

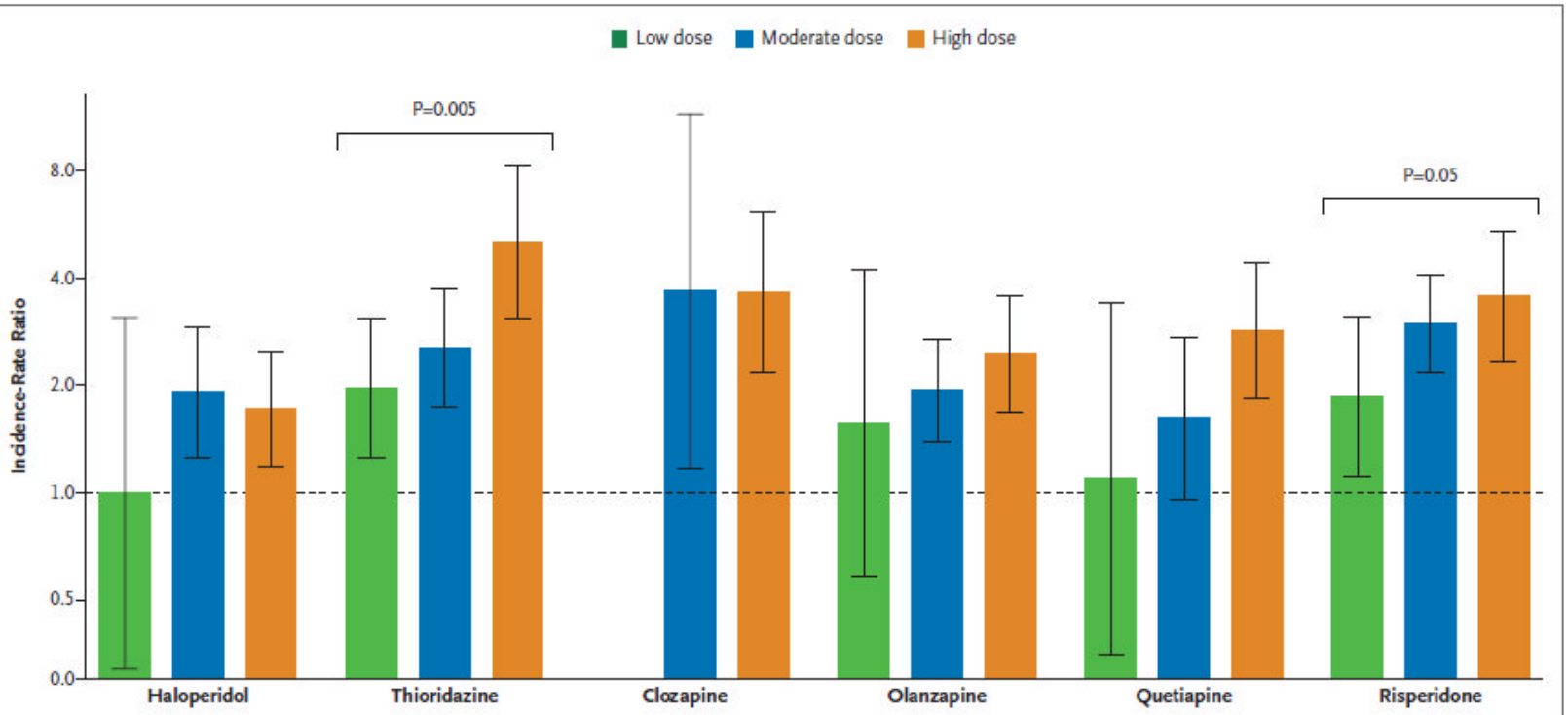
Figure 1. Adjusted Incidence-Rate Ratios for Sudden Cardiac Death among Current Users of Antipsychotic Drugs, According to Type of Drug and Dose.

Doses are shown as chlorpromazine equivalents: low dose, <100 mg; moderate dose, 100 to 299 mg; high dose, 300 mg or more. The reference category is nonusers of antipsychotic drugs. P values are for a dose–response relationship. I bars indicate 95% confidence intervals.

Wayne, RA et al. Atypical Antipsychotic Drugs and the Risk of Sudden Cardiac Death.

N Engl J Med 2009; 360: 225-235

The Risk of Sudden Cardiac Death and Antispychotics



No. of Deaths	3	23	32	20	28	17	0	3	16	4	40	31	3	15	22	15	46	24
No. of Person-Years	1342	7014	13,372	6238	7254	2223	63	593	3999	1640	15,395	10,222	2433	7983	6939	5894	12,950	5745
Incidence-Rate Ratio	1.00	1.92	1.72	1.97	2.55	5.05	—	3.67	3.66	1.57	1.94	2.45	1.09	1.62	2.85	1.86	2.98	3.56
95% CI	0.3–3.1	1.3–2.9	1.2–2.5	1.3–3.1	1.7–3.8	3.1–8.3	—	1.2–11.5	2.2–6.1	0.6–4.2	1.4–2.7	1.7–3.6	0.3–3.4	1.0–2.7	1.8–4.4	1.1–3.1	2.2–4.1	2.3–5.4

Figure 2. Adjusted Incidence-Rate Ratios for Sudden Cardiac Death among Current Users of Six Frequently Prescribed Antipsychotic Drugs, According to Dose.

Doses are shown as chlorpromazine equivalents: low dose, <100 mg; moderate dose, 100 to 299 mg; high dose, 300 mg or more. The reference category is nonusers of any antipsychotic drug. P values are for a dose–response relationship. I bars indicate 95% confidence intervals.

Wayne, RA et al. Atypical Antipsychotic Drugs and the Risk of Sudden Cardiac Death. N Engl J Med 2009; 360: 225-235

The Risk of Sudden Cardiac Death and Antipsychotics

Table 2. Adjusted Incidence-Rate Ratios for Sudden Cardiac Death, According to Use or Nonuse of Antipsychotic Drugs.*

User Status	No. of Person-Years	No. of Sudden Deaths	Incidence-Rate Ratio (95% CI)	P Value
Nonuser	624,591	895	Reference group	
Former user	189,981	311	1.13 (0.98–1.30)	0.08
Current user†				
Typical agent				
Any	86,735	255	1.99 (1.68–2.34)	<0.001
Haloperidol	21,728	58	1.61 (1.16–2.24)	0.005
Thioridazine	15,715	65	3.19 (2.41–4.21)	<0.001
Atypical agent				
Any	79,589	223	2.26 (1.88–2.72)	<0.001
Clozapine	4,654	19	3.67 (1.94–6.94)	<0.001
Olanzapine	27,257	75	2.04 (1.52–2.74)	<0.001
Quetiapine	17,355	40	1.88 (1.30–2.71)	<0.001
Risperidone	24,589	85	2.91 (2.26–3.76)	<0.001

* The total excludes 45,381 person-years and 134 deaths for indeterminate users of antipsychotic drugs, as well as 15,883 person-years and 52 deaths for concurrent users of multiple antipsychotic drugs.
† The analysis of these drugs included an adjustment for dose according to the method described in Appendix 1 in the Supplementary Appendix.

Wayne, RA et al. Atypical Antipsychotic Drugs and the Risk of Sudden Cardiac Death N Engl J Med 2009; 360: 225-235

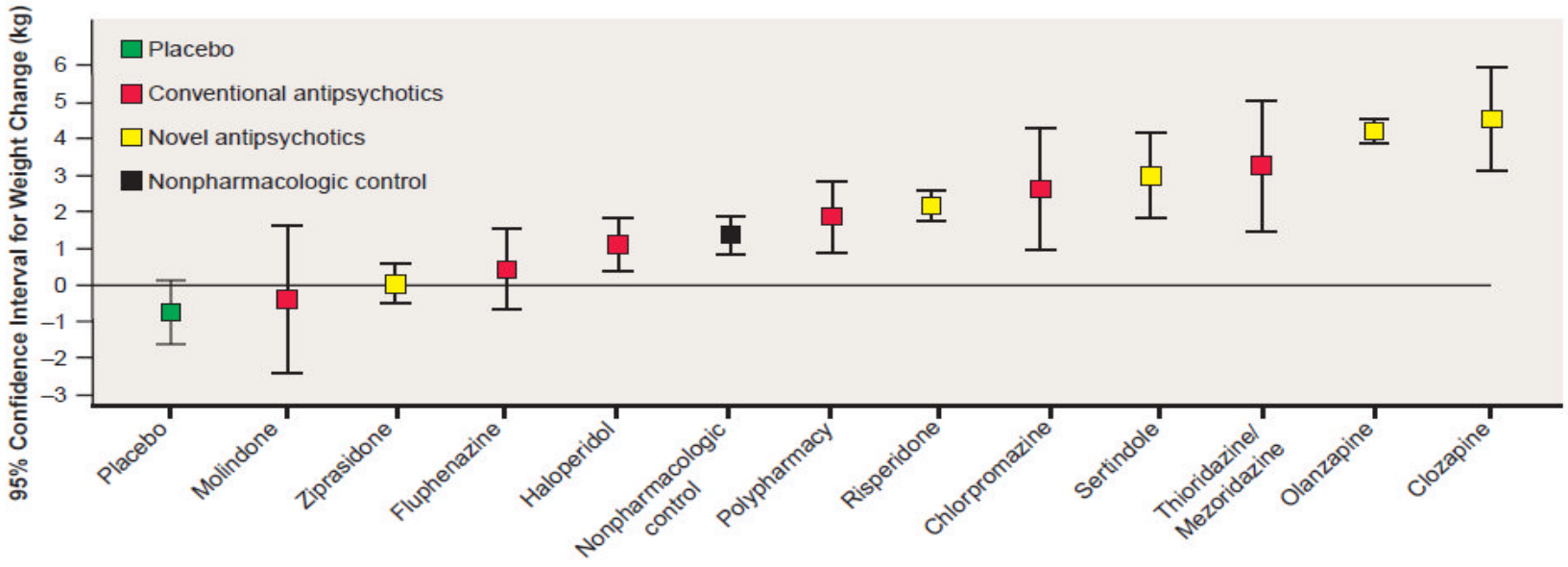
The Risk of Sudden Cardiac Death and Antipsychotics

- This new data may result in additional warnings being added to package inserts of both FGAs and SGAs
- Clinicians who use these medications off label should do so cautiously
- These medications should be used with caution in any disorder for which there are safer and equally effective agents available

Wayne, RA et al. Atypical Antipsychotic Drugs and the Risk of Sudden Cardiac Death. N Engl J Med 2009; 360: 225-235

Weight Gain & Various Antipsychotics

FIGURE 1. 95% Confidence Intervals for Weight Change After 10 Weeks on Standard Drug Doses, Estimated From a Random Effects Model



Allison, D et al. Antipsychotic Weight Gain: A Comprehensive Research Synthesis. Am J Psychiatry 1999; 156: 1686- 1696

Drug	Usual Dose (mg/day)	Approx Equiv Dose (mg)	Avg Monthly Cost
Fluphenazine(Prolixin)	2 to 20	10	$2.40
Haloperidol (Haldol)	5 to 20	10	$26.40
Loxapine(Loxitane)	20 to 100	50	$58.20
Molindone(Moban)	20 to 100	50	$150.00
Perphenazine(Trilafon)	8 to 84	40	$36.00
Thiothixene(Navane)	5 to 30	20	$16.20
Trifluoperizine(Stelazine)	5 to 30	25	$36.00
Chlorpromazine(Thorazine)	100 to 600	500	$9.00
Thioridazine(Mellaril)	100 to 600	500	$24.00
Risperidone(Risperdal)*	2 to 6	2	$29.00
Clozapine(Clozaril)*	300 to 600	250	$83.70
Ziprasidone(Geodon)*	80 to 160	120	$544.00
Olanzapine(Zyprexa)*	15 to 20	15	$565.00
Quetiapine(Seroquel)*	300 to 800	400	$607.00
Aripiprazole(Abilify)*	10 to 30	15	$486.00

*Estimated equivalent dose to 10mg oral Haloperidol :Textbook of Psychopharmacology 3rd Edition 2004

Adapted from: APA Guidelines 2004 & CNS News Special Edition Dec 2002

Pharmacy Orientation

Gregg Puffenberger, PharmD, MBA
MHM Services Inc
Director of Pharmacy Management
December 2008

Antipsychotic Medications in the Prison Population

- Despite the lack of controlled data in prison populations, you are still expected to make treatment decisions, particularly in the use of antipsychotic drugs. The results of published data in other populations and your own experience and clinical judgment, may not be directly translatable to patients in prison.

- Considering the obvious increase in psychotropic drug costs in recent years, the frequency of dosing, patient preference, hoarding of medications, utilization of medications for underground use as a commodity for bartering, and which side effects are likely to be either desirable or particularly undesirable in the correctional population should be considered when prescribing medications.

- Providing safe, appropriate, and cost-effective medication prescribing is a standard service MHM Prescribers provide to our Department of Corrections Clients.

American Journal of Psychiatry, Jan. 2007

SEROQUEL (Quetiapine) Abuse in Corrections

- Recent reports of quetiapine diversion and misuse among inmates in correctional settings where it is also called “quell” or “baby heroin” It is used orally, intranasally,and intravenously for its potent sedative and anxiolytic properties.

- Inmates obtain quetiapine for illegitimate use by malingering of psychotic symptoms or obtaining it from other inmates. The high prevalence of substance use disorders in corrections and the secondary gain of serving out “easy time” with pharmacological assistance contribute to an underground economy of diverted psychoactive medications.

- Quetiapine abuse may be more prevalent among prisoners because commonly abused drugs are less readily available. Another reason may be that quetiapine treats anxiety and sleeplessness associated with substance use withdrawal—with prisoners having high rates for these disorders. However, an internet search yielded a number of self-reports by individuals who believe they have become addicted to this agent. There is a popular rap song in which “seroquel”is included in a long list of addictive substances. In street jargon, quetiapine is known as “quell” and “Susie-Q.”

American Journal of Psychiatry, Sept 2004

- The clinicians report that often “monosymptomatic voices endorsed by patients are often assumed to represent psychosis and therefore lead to reflexive prescription of antipsychotic medications”.

- 30% of inmates seen in psychiatric services report malingered psychotic symptoms i.e. “hearing voices or ill defined paranoia” with “the absence of clear cut delusions or thought disorganization” in order to obtain medication.

- Intranasal Quetiapine abuse reported to be “widespread” among inmates at the LA County Jail.

American Journal of Psychiatry, Sept 2005

- Case report of an inmate injecting 600mg of Quetiapine intravenously.
  Patient fell asleep before she could remove the syringe from her forearm; acknowledged intranasal Quetiapine use in the past.

Psychotropic Tidbits

- There is little definitive data to guide us in the selection of a particular agent in any given class of psychotropic medication. *Therefore, if we can prescribe a more safe and cost effective medication, we should do it.* Our patients are more likely to continue their medication after leaving the Department of Corrections if we start them on less costly medications.

- Medications can only work if they are taken at an adequate dose for an adequate length of time. It may be necessary to try high doses of some monotherapies in partial responders who have NO side effects at therapeutic doses.

- Therapeutic trials of sufficient duration and with optimal dosages of a single agent should be tried before adding another agent. Ineffective or minimally effective medications should be discontinued sooner rather than later.

- Polypharmacy may increase the risk of morbidity and mortality, is frequently ineffective, expensive, and increases the amount of nursing time spent on ordering, storing and administering medications instead of caring for the patients.

Strategies for Use of Psychotropics

- Many of MHM current clients and Request for Proposals require the development and implementation of treatment guidelines that outline strategies for the use of psychotropic medications for various mental illnesses.

- The MHM treatment guidelines are based on guidelines of national level organizations , including the American Psychiatric Association and the Texas Medical Algorithms Project. Development of treatment guidelines included researching peer reviewed literature to gain an understanding of other applications of similar guidelines with special attention to comparing safety, efficacy and side effects. MHM also compared the treatment guidelines to the standards of correctional mental health providers. The MHM treatment guidelines are regularly reviewed by MHM Medical Directors for revision in form and content.

- While treatment guidelines provide strategies for prescribing psychotropic medication, the guidelines include the statement: “Treatment guidelines do not replace sound clinical judgment nor are they intended to strictly apply to all patients.”

Psychotropic Orders

- The psychiatrist or nurse practitioner prescribes psychotropic medications consistent with the Client's FORMULARY whenever clinically possible. To use Non-Formulary psychotropic medications, the psychiatrist or nurse practitioner must submit a Non-Formulary Request form. The non-formulary request must be approved by the Medical Director or his designee prior to ordering the psychotropic medication. (Form at end of Section)

- Psychotropic medication should not be the first treatment provided for inmate reports of sleep problems. Sleep disturbance should initially be addressed through sleep hygiene techniques. Document objective observations in relation to inmate complaints. (Appears well rested vs. appears sleep deprived")

- Prescribing three or more classes of psychotropic medications is considered non-formulary and requires the approval of the Mental Health Director.

Psychotropic Orders

- Unless contraindicated, Atypical Antipsychotics medications should be prescribed to be administered once daily.

- Prescribing more than two separate psychotropic medications in the same class is considered non-formulary and requires approval of the Mental Health Medical Director.
- Standing orders for any PRN psychotropic medications are prohibited.

- Use of benzodiazepines is restricted. Ordering benzodiazepines in other than an emergency requires the approval of the Mental Health Medical Director.

- MEDICAL SERVICES are available within the DOC. Ideally, any medication, profile, lab study, should be ordered for psychiatric indications. If there is a concern about physical health issues, physical medicine should be consulted.

Outcome Measures of CATIE

CATIE RESULTS NEJM 2005							
					Facts & Comparisons		
Generic (Brand) .	Weight Change lbs.	Blood Glucose mg/dl	Cholesterol mg/dl	Triglyceride mg/dl	Prolactin ng/dl	Sedative Effect	Orthostatic HTN
P Value	P < 0.001	P 0.59	P < 0.001	P < 0.001	P < 0.001		
Olanzapine (Zyprexa)	9.4 +- 0.9	13.7 +- 2.5	9.4 +- 2.4	40.5 +- 8.9	(8.1)+-1.4	+++	++
N = 336							
Quetiapine (Seroquel)	1.1 +- 0.9	7.5 +- 2.5	6.6 +- 2.4	21.2 +- 9.2	(10.6)+-1.4	+++	++
N= 337							
Risperidone (Risperdal)	0.8 +- 0.9	6.6 +- 2.5	(1.3) +-2.4	(2.4) +-9.1	13.8 +- 1.4	+	+
N = 341							
Perphenazine (Trilafon)	(2.0)+-1.1	5.4 +- 2.8	1.5 +- 2.7	9.2 +- 10.1	(1.2) +- 1.6	++	++
N = 261							
Ziprasidone (Geodon)	(1.6)+-1.1	2.9 +- 3.4	(8.2) +-3.2	(16.5) +-12.2	(5.6) +- 1.9	+	+
N = 185							

HALDOL (HALOPERIDOL) : *SCHIZOPHRENIA*

There is significant variation between patients in the amount of medication required; DOSAGE must be individualized. The normal dosage range for initiation of therapy for psychiatric indications is 1 to 6 milligrams/day for moderate and 6 to 15 milligrams/day for severe symptomatology, divided into 2 to 3 doses.

MANIA

*D*oses in excess of 10 mg/day offered no advantage in controlling symptoms of mania

TRILAFON (PERPHENAZINE): *SCHIZOPHRENIA*

DOSES of 4 to 8 milligrams orally three times a day initially can be administered to moderately disturbed Nonhospitalized schizophrenic patients (Prod Info Trilafon(R), 2002). In hospitalized schizophrenic patients, 8 to 16 milligrams orally two to four times a day can be administered. Doses in excess of 64 milligrams daily should be avoided (Prod Info Trilafon(R), 2002).

THORAZINE (CHLORPROMAZINE) : *BIPOLAR DISORDER, MANIC EPISODE*

In hospitalized patients who are severely manic or acutely disturbed, the recommended DOSE of chlorpromazine is 25 milligrams 3 times daily. After 1 or 2 days the dose may be increased by 25 to 50 mg at semiweekly intervals until The patient becomes calm and cooperative (Prod Info Thorazine(R), 02e). In hospitalized patients who are less manic or less acutely disturbed, the recommended dose of chlorpromazine is 25 milligrams (mg) 3 times daily. Increase gradually until effective dose is reached. Doses are usually about 400 mg daily. In outpatients, 10 mg 3 or 4 times daily or 25 mg 2 or 3 times daily may be used

SCHIZOPHRENIA

In schizophrenic outpatients, DOSES of 50 to 400 milligrams (mg)/day are usually Sufficient. Dosage of chlorpromazine in hospitalized schizophrenic patients has ranged from 200 to 1600 mg/day, with doses usually starting at 100 to 200 mg/day and increasing gradually.

MOLINDONE: *SCHIZOPHRENIA*

Initial, 50 to 75mg ORALLY daily in 3 to 4 doses, increased to 100 mg/day in 3 or 4 days

Maintenance - mild psychosis: 5 to 15mg ORALLY 3 to 4 times a day

moderate psychosis: 10 to 25mg ORALLY 3 to 4 times a day

severe psychosis: MAX up to 225 mg/day ORALLY in divided doses

LOXAPINE SUCCINATE: *SCHIZOPHRENIA*

Initial, 10 mg ORALLY twice daily (in more severe cases, dosages up to 50 MG ORALLY per day may be used); may increase dosage rapidly during the first 7-10 days to reach the usual effective range of 60-100 mg/day in 2-4 divided doses (MAX daily dosage is 250 mg)

SSRIs POTENTIAL FOR DRUG INTERACTIONS

Medications	Possible Results	Severity	Substantiation
MAOI's	Serotonin Syndrome	Major	Probable
Tramadol	Increased Serotonin	Major	Theoretical
TCA's	Increased TCA levels	Major	Probable
Clomipramine	Serotonin Syndrome	Major	Probable
Imitrex 5HT (Triptans)	Serotonin Syndrome	Major	Theoretical
Erythromycin	Serotonin Syndrome	Major	Probable
Zyvoxx	Serotonin Syndrome	Major	Probable
Wellbutrin	Increased risk of Seizures	Moderate	Probable
Lithium	Lithium Toxicity	Moderate	Established
Tegretol	Increase Tegretol Levels	Moderate	Probable
Phenytoin	Increase Phenytoin Levels	Moderate	Probable
Lamictal	Lamictal Toxicity	Moderate	Probable
Clozapine	Clozapine Toxicity	Moderate	Probable
NSAIDs	Increased risk of GI Bleeding	Moderate	Probable
Celebrex	Increased risk of GI Bleeding	Moderate	Probable
Methadone	Increase Methadone Levels	Moderate	Theoretical
Warfarin	Increased risk of Bleeding	Moderate	Theoretical

Atypical Drug Interactions

POTENTIAL FOR DRUG INTERACTIONS			
CYP Enzyme	ANTIPSYCHOTICS	INHIBITORS	INDUCERS
Subtype	Metabolized	May Increase Drug Levels	May Decrease Drug Levels
CYP 1A2 .	CLOZAPINE OLANZAPINE	INTERFERON .	INSULIN TOBACCO
CYP 2D6	ARIPIPRAZOLE CLOZAPINE OLANZAPINE RISPERIDONE	RITONAVIR	
CYP 3A4	ARIPIPRAZOLE CLOZAPINE QUETIAPINE ZIPRASIDONE	DELAVIRADINE INDINAVIR NELFINAVIR RITONAVIR	CARBAMAZEPINE EFAVIRENZ NEVIRAPINE PHENOBARBITAL PHENYTOIN

5 Strategies for Non-Formulary Requests

- Reference evidence-based information to support your request.
- Document your drug trials, dosages, clinical response failure, and adverse effects. to expedite review of nonformulary requests.
- Ask the patient about family history of response to a medication. Such pharmacogenetic data may predict response in first-degree relatives and support a nonformulary request.
- Document pharmacokinetic or pharmacodynamic interactions between the formulary drug and other medications the patient is taking.
- List known interactions with foods and diseases.

5 Tips for Practicing Within a Formulary

- Formularies are well intentioned and are updated frequently to represent physicians' and other experts' clinical judgment on the use of SAFE, APPROPRIATE, and cost-effective medications, therapies that best serve patients.

- Address concerns to help your staff accept and adhere to prescribed formulary drugs. Emphasize that a medication's cost does not determine its efficacy.

- The decision to provide proper treatment supersedes cost considerations.

- Use nonpharmacologic treatments such as sleep hygiene, cognitive-behavioral therapy, or relaxation techniques when possible. This approach reduces polypharmacy.

- A Non-Formulary review of a medication can be submitted for addition to the formulary.

Vermont Formulary 12-08

Please Consider Tier 1 medications , if clinically appropriate, before going to Tier 2		
Tier 1	Tier 2	Non-Formulary
	Novel Anti-Depressants	
BUPROPION SR	VENLAFAXINE	Budeprion XR/BuproXL
BUPROPION	NEFAZADONE	DULOXETINE
MIRTAZAPINE	MAPROTILINE	Effexor XR
TRAZODONE HCL		
	SSRI's	
CITALOPRAM	FLUVOXAMINE	
FLUOXETINE	PAROXETINE	
SERTRALINE		
	TCA's	
AMITRIPTYLINE	TRIMIPRAMINE	
AMITRIPTYLINE/PERPHEN	CLOMIPRAMINE	
DOXEPIN	AMOXIPINE	
NORTRIPTLINE		
DESIPRAMINE		
IMIPRAMINE		
	Anti-Psychotics	Non-Formulary
CLOZAPINE	ZIPRASIDONE	QUETIAPINE
RISPERDIONE	RISPERDAL - CONSTA	OLANZAPINE
		ARIPIPRAZOLE
		PALLIPERIDONE
CHLORPROMAZINE	THIORIDAZINE	
FLUPHENAZINE		
HALOPERIDOL		
LOXAPINE		
MOLINDONE		
PERPHENAZINE		
THIOTHIXINE		
TRIFLUOPERAZINE		
	Mood Stabilizers	
VALPROIC ACID		TOPIRAMATE
LITHIUM	CARBAMAZEPINE	OXCARBAMAZEPINE
DEPAKOTE	LAMOTRIGINE	GABAPENTIN
	MAO Inhibitors	
		PHENYLZINE
		TRANYLCYPROMINE
		SELEGILINE
		ISOCARBOXIZID
	MISCELLANEOUS	
PROPRANOLOL		
CLONIDINE		
GUANFACINE		

Average cost of 30 day of Antipsychotics

Drug	Cost per tab	Dose per Day	Monthly Cost
FLUPHENAZINE HCL 10MG TAB	$0.08	10mg	$2.40
HALOPERIDOL DEC AMP 100MG	$4.72	100mg	$4.72
CHLORPROMAZINE HCL 200MG TAB	$0.15	400mg	$9.00
THIOTHIXENE 10MG CAP	$0.18	30mg	$16.20
PERPHENAZINE 16MG TAB	$0.34	32mg	$20.40
THIORIDAZINE HCL 100MG TAB	$0.20	400mg	$24.00
HALOPERIDOL 10MG TAB	$0.88	10mg	$26.40
FLUPHENAZINE DECANOATE 25MG/ML	$1.06	25mg	$31.80
TRIFLUOPERAZINE HCL 5MG TAB	$0.40	15mg	$36.00
LOXAPINE SUCCINATE 50MG CAP	$0.97	100mg	$58.20
CLOZAPINE 100MG TAB	$0.93	300mg	$83.70
Generic RISPERDAL 4MG (NEW)	$1.00	4mg	$30.00
GEODON 80MG CAP	$6.38	160mg	$382.80
ABILIFY 20MG TAB	$16.21	20mg	$486.30
ZYPREXA 15MG TAB	$16.36	15mg	$490.80
SEROQUEL 300MG TAB	$8.62	600mg	$517.20
GEODON 80MG CAP	$6.38	240mg	$544.20
SEROQUEL XR 400MG	$9.47	800mg	$568.20
SEROQUEL 400MG TAB	$10.13	800mg	$607.80
RISPERDAL CONSTA 50MG INJ	$478.27	50mg q 2wks	$956.54

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RISPERDAL CONSTA 50MG INJ	$478.27	50mg q 2wks	$956.54

Average Cost of 30 day supply of Anti-depressants

Drug	Cost per tab	Dose per day	Monthly Cost
FLUOXETINE HCL 20MG CAP	$0.02	20mg	$0.60
AMITRIPTYLINE HCL 75MG TAB	$0.03	75mg	$0.90
CITALOPRAM HYDROBROMIDE 40MG	$0.04	40mg	$1.20
BUSPIRONE HCL 15MG TAB	$0.04	15mg	$1.20
SERTRALINE HCL 100MG TAB	$0.05	100mg	$1.50
DOXEPIN HCL 75MG CAP	$0.06	75mg	$1.80
CLOMIPRAMINE HCL 50MG CAP	$0.07	50mg	$2.10
TRAZODONE HCL 150MG TAB	$0.08	150mg	$2.40
MIRTAZAPINE 30MG TAB	$0.14	30mg	$4.20
PAROXETINE HCL 30MG TAB	$0.16	30mg	$4.80
IMIPRAMINE HCL 50MG TAB	$0.19	50mg	$5.70
BUPROPION HCL 100MG TAB	$0.14	300mg	$12.60
NEFAZODONE HCL 100MG TAB	$0.32	200mg	$19.20
BUPROPION HCL 150MG SR TAB	$0.48	300mg	$28.80
LEXAPRO 10MG TAB	$2.27	10mg	$68.10
CYMBALTA 60MG CAP	$3.34	60mg	$100.20
EFFEXOR XR 150MG CAP	$3.64	150mg	$109.20

Average Cost of 30 day supply of Mood Stabilizers

Drug	Cost Per Tab	Dose per Day	Cost per Month
CARBAMAZEPINE 200MG TAB	$0.04	400mg	$2.40
LITHIUM CARBONATE 300MG CAP	$0.03	900mg	$2.70
GABAPENTIN 800MG TAB	$0.22	800mg	$6.60
Generic DEPAKOTE 500MG (New)	$0.13	1500mg	$11.70
LITHIUM CARBONATE 450MG ER TAB	$0.22	900mg	$14.40
VALPROIC ACID 250MG CAP	$0.16	1500mg	$25.20
LAMICTAL 200MG TAB	$4.61	200mg	$138.30
OXCARBAZEPINE 600MG TAB	$3.36	1200mg	$201.60
DEPAKOTE ER 500mg	$2.78	1500mg	$250.20
DEPAKOTE 500MG TAB	$2.98	1500mg	$268.20
TOPAMAX 50MG TAB	$3.55	200mg	$426.00

The American Correctional Association
and the
Commission on Accreditation for Corrections
awards

ACCREDITATION

to

Massachusetts Department of Correction

Souza Baranowski Correctional Center

Shirley, Massachusetts

2009-2012

in recognition of the attainment of excellence in the operation of

an Adult Correctional Institution

presented this 10th ***day of*** August 2009

ACA PRESIDENT

ACA EXECUTIVE DIRECTOR

COMMISSION ON ACCREDITATION FOR CORRECTIONS
ACA
FOUNDED 1870
AMERICAN CORRECTIONAL ASSOCIATION

COMMISSION CHAIR

DIRECTOR, STANDARDS AND ACCREDITATION

COMMISSION ON ACCREDITATION FOR CORRECTIONS

AND THE

AMERICAN CORRECTIONAL ASSOCIATION

COMPLIANCE TALLY

Manual Type	Adult Correctional Institutions, Fourth Edition
Supplement	2008 Standards Supplement
Facility/Program	Souza Baranowski Correctional Center
Audit Dates	May 4-6, 2009
Auditor(s)	Robert Conley, Chairperson; Bonnie Boyette, Member, Gerald Ellsworth, Member

	MANDATORY	**NON-MANDATORY**
Number of Standards in Manual	61	469
Number Not Applicable	2	31
Number Applicable	59	439
Number Non-Compliance	0	1
Number in Compliance	59	438
Percentage (%) of Compliance	100%	99.7%

- Number of Standards *minus* Number of Not Applicable *equals* Number Applicable
- Number Applicable *minus* Number Non-Compliance *equals* Number Compliance
- Number Compliance *divided by* Number Applicable *equals* Percentage of Compliance

1145 W. Diversey Parkway
Chicago, IL 60614
(773) 880-1460 phone
(773) 880-2424 fax
ncchc@ncchc.org
www.ncchc.org

March 13, 2009

Thomas Brown
Sheriff
DeKalb County Jail
4415 Memorial Dr.
Decatur, GA 30032-1337

Dear Mr. Brown,

Congratulations! The Accreditation Committee of the National Commission on Correctional Health Care (NCCHC), upon receipt of further documentation, voted to continue to accredit DeKalb County Jail for its compliance with NCCHC's *Standards for Health Services in Jails.* Enclosed is the accreditation report; the Certificate of Accreditation will follow.

NCCHC congratulates you on your achievement and wishes you continued success in the future. It is anticipated that the next scheduled on-site survey of the facility will occur sometime prior to October 2011. If we can be of any assistance to you, please feel free to call us at any time.

Sincerely

Jennifer E. Kistler, MPH
Director of Accreditation
Enclosures

CC: Edward A. Harrison, NCCHC President
Heather S Miller, Health Services Coordinator
Shirley A McArthur, RN, MSN, FNP, Site Manager

Baltimore City Detention Center, MD
June 26, 2009

The National Commission on Correctional Health Care is dedicated to improving the quality of correctional health services and helping correctional facilities provide effective and efficient care. NCCHC grew out of a program begun at the American Medical Association in the 1970s. The standards are NCCHC's recommended requirements for the proper management of a correctional health services delivery system. These standards have helped correctional facilities improve the health of their inmates and the communities to which they return, increase the efficiency of their health services delivery, strengthen their organizational effectiveness, and reduce their risk of adverse patient outcomes and legal judgments.

On May 19-212009, NCCHC conducted its review for continued accreditation of this facility. We commend the facility staff for their professional conduct, assistance, and candor during the course of our review.

The NCCHC's team of experienced certified correctional health professionals utilized NCCHC's 2008 *Standards for Health Services in Jails* as the basis of its health services analysis. This report focuses primarily on issues in need of correction or enhancement. It is most effective when read in conjunction with the *Standards* manual.

There are 35 essential standards; 34 are applicable to this facility and 29 (85%) were found to be in compliance. One hundred percent of the applicable essential standards must be met. Our findings include:

Essential Standards Not in Compliance

J-C-06	Inmate Workers
J-D-01	Pharmaceutical Operations
J-D-02	Medication Services
J-E-01	Information on Health Services
J-E-07	Nonemergency Health Care Requests and Services

Essential Standard Not Applicable

J-E-02	Receiving Screening

There are 32 important standards; 31 are applicable to this facility and 30 (97%) were found to be in compliance. Eighty-five percent or more of the applicable important standards must be met. Our findings include:

Important Standards Not in Compliance

J-F-02	Medical Diets

Important Standard Not Applicable

J-C-08	Health Care Liaison

Decision: On June 26, 2009, NCCHC's Accreditation Committee awarded the facility Continuing Accreditation with Verification (CAV), *contingent* upon receiving requested compliance verification by October 9, 2009.

The Joint Commission

July 23, 2009

Karin T. Bergeron
Superintendent
Bridgewater State Hospital
20 Administration Road
Bridgewater, MA 02324

Joint Commission ID #: 363109
Program: Behavioral Health Care Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 07/23/2009

Dear Ms. Bergeron:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Behavioral Health Care

This accreditation cycle is effective beginning April 17, 2009. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 39 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

The Joint Commission

Bridgewater State Hospital
20 Administration Road
Bridgewater, MA 02324

Organization Identification Number: 363109

Evidence of Standards Compliance (60 Day) Submitted: 7/8/2009

Program(s)
Behavioral Health Care Accreditation

Executive Summary

Behavioral Health Care Accreditation :	As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified. You will have follow-up in the area(s) indicated below: • Measure of Success (MOS) – A follow-up Measure of Success will occur in four (4) months.

If you have any questions, please do not hesitate to contact your Account Representative.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

The Joint Commission
Summary of Compliance

Program	Standard	Level of Compliance
BHC	IM.6.20	Compliant
BHC	NPSG.02.03.01	Compliant
BHC	PC.12.130	Compliant
BHC	PC.4.40	Compliant

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

CERTIFICATE OF COMPLIANCE

This Certificate is hereby granted to **PHILADELPHIA PRISON SYSTEM**
(LEGAL ENTITY)

To operate **PHILADELPHIA PRISON SYSTEM**
(NAME OF FACILITY OR AGENCY)

Located at **7901 STATE ROAD, THIRD FLOOR, PHILADELPHIA, PA 19136**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

(ADDRESS OF SATELLITE SITE) (ADDRESS OF SATELLITE SITE)

(ADDRESS OF SATELLITE SITE) (ADDRESS OF SATELLITE SITE)

(ADDRESS OF SATELLITE SITE) (ADDRESS OF SATELLITE SITE)

To provide **Psychiatric Unit**
(TYPE OF SERVICE(S) TO BE PROVIDED)

The total number of persons which may be cared for at one time may not exceed **64** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

This certificate is granted in accordance with the Public Welfare Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 5100: Mental Health Procedures
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **September 24,** **2009** until **September 24,** **2010**
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **103250**

Robert E. Robinson
ISSUING OFFICER

DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

PW 628 - 4/02

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
BUREAU OF OPERATIONS AND QUALITY MANAGEMENT
DIVISION OF EASTERN OPERATIONS
100 LACKAWANNA AVENUE - ROOM 321
SCRANTON, PENNSYLVANIA 18503

Michael J. Orr, Manager
Scranton Field Office
E-Mail: morr@state.pa.us

Telephone: (570) 963-4335
Fax: (570) 963-3050

April 30, 2009

Mr. Joseph Nish, Superintendent
State Correctional Institution – Waymart
P.O. Box 256
Waymart, Pennsylvania 18472-0256

Dear Mr. Nish:

On April 16, 2009, a Forensic Hospital Survey Team from the Office of Mental Health and Substance Abuse Services conducted the annual survey of the Inpatient Psychiatric Unit at SCI-Waymart. Following Title 55, Chapter 5333, Inpatient Forensic Psychiatric Hospital Regulations, the Team surveyed all components of the unit's operation. We are pleased to inform you that the Inpatient Forensic Unit is approved to operate by the Office of Mental Health and Substance Abuse Services for the period from March 25, 2009, to March 25, 2010. Approval is based on compliance with aforementioned Chapter 5333 Regulations.

Attached you will find reports of the Survey Team delineating their findings for the services in the Forensic Treatment Center.

I want to thank you and Deputy Superintendent DelRosso for the courtesy and cooperation extended by all staff to the Survey Team during their visit. As always, the Office of Mental Health and Substance Abuse Services' staff is available to provide consultation or technical assistance to the staff of the Inpatient Unit upon request.

Sincerely,

Michael J. Orr

Attachments

cc: Ms. Helen E. Dingle

MHM Services Inc.
NEW EMPLOYEE ORIENTATION

GENERAL TOPICS REQUIRED FOR ALL NEW STAFF

TOPIC	Number of Slides	Handouts?	Post Test?	Answer Key
Introduction to Corrections	27	No	Yes	Yes
Boundaries and Safe Practices	29	Yes	Yes	Yes
Confidentiality, HIPAA & PREA	23	Yes	Yes	Yes
Infection Control	51	Yes	Yes	Yes
Hazardous Communication	24	Yes	Yes	Yes
Continuous Quality Improvement	33	No	Yes	Yes
Signs & Symptoms of Mental Illness	27	Yes	Yes	Yes
Suicide Prevention	29	Yes	Yes	Yes
Emergency Responses	18	No	Yes	Yes
Use of Restraints	27	Yes	Yes	Yes

HEALTHCARE OVERVIEW REQUIRED FOR ALL NEW CLINICAL STAFF

TOPIC	Number of Slides	Handouts?	Post Test?	Answer Key
Access to Healthcare	48	Yes	Yes	Yes
Healthcare Requests	21	Yes	Yes	Yes
Continuity of Healthcare	19	Yes	Yes	Yes
Documentation	32	No	Yes	Yes
Mental Health Services	18	Yes	Yes	Yes
Special Healthcare Considerations in Inmate Population	44	Yes	Yes	Yes
Healthcare Services for Segregated Inmates	21	Site Specific	Yes	Yes
Chronic Disease & Healthy Lifestyle Promotion	24	Yes	Yes	Yes
Specialty Services	21	Yes	Yes	Yes
Inmate Death	19	No	Yes	Yes
Tools & Sharps Control	15	Yes	Yes	Yes

ORIENTATION REQUIRED FOR MEDICAL/NURSING STAFF

TOPIC	Number of Slides	Handouts?	Post Test?	Answer Key
Sick Call & Access to Healthcare	25	Yes	Yes	Yes
Medication Practices in Correctional Environment	55	Yes	Yes	Yes
Healthcare Screenings	35	Yes	Yes	Yes
Initial Health Assessment	27	Yes	Yes	Yes
Intoxication, Drug Overdose & Withdrawal	44	Yes	Yes	Yes
Tuberculosis	24	Yes	Yes	Yes
Wound Care & MRSA	10	Yes	Yes	Yes
Oral Care	10	Yes	Yes	Yes
Infirmary Care	16	No	Yes	Yes

Delaware Department of Correction

General Statistics for Prescribers:

- Approximately 100 Psychiatrists Living & Licensed in Delaware
- Approximately 30 Psychiatric/Mental Health NPs and CNSs Living & Licensed in Delaware

Breakdowns and Additional Information per Specific Facility & Area:

Young Correctional Institution
Wilmington, Delaware
*35 miles from Philadelphia

Approximately 1294 Psychiatrists w/in 45 mile radius. *Note: Only a small percentage of these Psychiatrists have an active DE license. Licensing services can be offered/recommended for interested candidates who do not have a DE license.

Baylor Women's Correctional Institution
New Castle, Delaware
*40 miles from Philadelphia
*45 miles from Dover
*75 miles from Baltimore

Approximately 55 Psychiatrists w/in 45 mile radius.
The state's only Psychiatry Residency is in New Castle – Delaware Psychiatric Center Program.

James T. Vaughn Correctional Center
Smyrna, DE
*12 miles from Dover

Approximately 29 Psychiatrists w/in 45 mile radius.

Sussex Correctional Institution
Sussex Boot Camp
Georgetown, DE
*30 miles from Salisbury, MD
*36 miles from Dover

Approximately 45 Psychiatrists w/in 45 mile radius.

INDEX TO STAFF TRAINING MODULES (Effective May 2009)

TITLE/GOAL OF TRAINING	OUTLINE OF TRAINING	RECOMMENDED PARTICIPANTS	ESTIMATED DURATION OF TRAINING
INTRODUCTION TO MENTAL DISORDERS: Increase appreciation for implications of mental disorders for correctional settings	Overview of mental disorders frequently encountered in corrections: Mental Illness; Substance Abuse; Mental Retardation Signs and symptoms of serious mental illness and mental retardation Impact of serious mental illness and/or mental retardation Roles of correctional officers and treatment staff in working together	New mental health staff Medical staff Facility administrative staff Correctional officers	3 hours
TYPES OF MENTAL ILLNESS: Increase understanding of serious mental illnesses that are experienced by inmates/detainees	Overview of serious mental illness Signs and symptoms of Schizophrenia Signs and symptoms of Major Depression Signs and symptoms of Bipolar Disorder Signs and symptoms of Organic Brain Syndrome Other mental illnesses Personality Disorders	New mental health staff Medical staff Correctional officers assigned to mental health units	2 hours
MENTAL ILLNESS IN CORRECTIONS: Increase appreciation for reasons why persons with serious mental illness are incarcerated and the constitutional requirements when persons with serious mental illness are incarcerated	Legal obligation of corrections when an inmate/detainee experiences a serious mental illness Impact of inmates/detainees with serious mental illness on correctional operations Why persons with serious mental illness are incarcerated Roles of correctional officers and treatment staff in working together	New mental health staff Medical staff Facility administrative staff Correctional officers	2 hours
MANAGEMENT AND TREATMENT OF INMATES WITH SERIOUS MENTAL ILLNESS: Increase appreciation for management and treatment strategies that maximize positive outcomes for inmates/detainees with serious mental illness	Techniques for effectively managing persons with serious mental illness. Treatment interventions for serious mental illness. Introduction to psychotropic medication. Introduction to treatment planning process. Cooperation of security and treatment staff in management and treatment of inmates/detainees with serious mental illness	New mental health staff Medical staff Correctional officers	3 hours
MENTAL RETARDATION: Increase understanding of mental retardation and how this disability impacts a person when incarcerated	What is mental retardation Prevalence, causes and impact of mental retardation Impact of inmates/detainees with mental retardation on correctional operations Behavioral signs that an inmate/detainee may experience mental retardation Management techniques for inmates/detainees with mental retardation	New mental health staff Medical staff Correctional officers	1 - 2 hours

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TITLE/GOAL OF TRAINING	OUTLINE OF TRAINING	RECOMMENDED PARTICIPANTS	ESTIMATED DURATION OF TRAINING
SUICIDE PREVENTION: Increase awareness for the potential of suicide within a correctional institution and the interventions that reduce incidence of suicide	General facts about suicidal behavior Increased risk of suicide in corrections Suicide prevention efforts within corrections Factors that increase potential for suicidal behavior in corrections Signs to identify an inmate/detainee at risk for suicide Interviewing inmates/detainees to determine potential of suicide risk Management techniques for inmates/detainees at risk for suicide Impact when suicide occurs within correctional facility	New mental health staff Medical staff Correctional officers Facility administrative staff	3 hours
DSM MULTIAXIAL DIAGNOSES: Increase understanding of the purpose and application of the five diagnostic axes recognized by the American Psychiatric Association	THIS IS BASIC/INTRODUCTORY TRAINING IN DIAGNOSTICS. FOR MORE EXTENSIVE TRAINING CONSIDER THE 25 MODULE DIAGNOSTIC TRAINING SERIES PROVIDED IN AN OTHER MANUAL. What is a diagnosis How is a diagnosis formulated Purpose of Diagnostic and Statistical Manual of Mental Disorders) Axis I: Clinical Disorders and Other Conditions that May Be Focus of Clinical Attention Axis II: Personality Disorders and Mental Retardation Axis III: General Medical Conditions Use of diagnostic codes for Axis I, II and III diagnoses Axis IV: Psychosocial and Environmental Problems Axis V: Global Assessment of Functioning Role of “team” in diagnostic decisions	Mental health staff Medical staff	2 - 3 hours
TREATMENT PLANNING: Increase staff skills in the development of clinically appropriate and realistic treatment plans	THIS IS BASIC/INTRODUCTORY TRAINING IN TREATMENT PLANNING. FOR MORE EXTENSIVE TRAINING CONSIDER THE FIVE MODULE TRAINING LISTED ON PAGE 8 OF THIS INDEX Purpose of treatment planning NCCHC standards related to treatment planning Multidisciplinary approach to treatment planning Components of treatment plans Risk management plan Treatment plan documentation and reviews	New mental health staff Correctional officers assigned to mental health units	2 hours

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TITLE/GOAL OF TRAINING	OUTLINE OF TRAINING	RECOMMENDED PARTICIPANTS	ESTIMATED DURATION OF TRAINING
THERAPEUTIC COMMUNICATION: Increase appreciation for the effectiveness of therapeutic communication when working with inmates/detainees	What is therapeutic communication? Ways to communicate Verbal communication Non-verbal communication Identifying non-verbal cues presented by inmates/detainees Active listening Goals of therapeutic communication Inmate/detainee styles that compromise therapeutic communication Perception of staff who use therapeutic communication techniques	New mental health staff Medical staff Correctional officers	1 - 2 hours
PSYCHOTROPIC MEDICATION: Increase understanding of the benefits and potential negative side effects when psychotropic medication is taken to manage serious mental illness	Role of psychotropic medication in the treatment of serious mental illness Benefits of taking psychotropic medication Serious side effects that may occur when taking psychotropics Chronic side effects that may occur when taking psychotropics Types of psychotropic medication Why inmates may not regularly accept psychotropic medication Importance of monitoring medication compliance	New mental health staff Medical staff Correctional officers, particularly those assigned to mental health units	1.5 hours
AIMS TESTING: Increase understanding of the purpose and procedures of AIMS testing	Purpose of AIMS testing General instructions in completing examination AIMS testing procedures: demonstration	Mental health nurses Psychiatrists Nurse practitioners	1 hour - additional time if video(s) used
BLOODBORNE PATHOGENS EXPOSURE CONTROL PLAN: Increase understanding of OSHA's Occupational Exposure to Bloodborne Pathogens and the MHM Exposure Control Plan	Introduction to OSHA Occupational Exposure to Bloodborne Pathogens Standard Epidemiology and symptoms of bloodborne diseases Modes of transmission of bloodborne pathogens MHM Bloodborne Pathogens Exposure Control Plan Responsibilities for implementation of Exposure Control Plan Recognizing and identifying staff at risk Prevention and minimization of exposures Universal Precautions; Engineering Controls; Work Practice Controls; Personal Protective Equipment; Decontamination; Housekeeping Biohazard warnings Hepatitis B vaccine information Exposure reporting procedures Post-exposure evaluation and procedures	New mental health staff Correctional officers Offender janitorial workers Handouts may be used for OSHA required immediate orientation of staff to Bloodborne Pathogens Exposure Control Plan. MHM plan indicates full training will occur within 30 days of hire with annual updates.	2 hours

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TITLE/GOAL OF TRAINING	OUTLINE OF TRAINING	RECOMMENDED PARTICIPANTS	ESTIMATED DURATION OF TRAINING
BEHAVIORAL MANAGEMENT AND DE-ESCALATION SKILLS WITH AGGRESSIVE AND SELF-INJURIOUS INMATES: Increase understanding of basic behavioral principles and de-escalation skills for reducing self-injurious and aggressive behaviors in inmates/detainees	The helping relationship Challenges to the helping relationship: the aggressive and self-injurious inmate Our natural reactions and staff splitting Introduction to behavioral management principles and interventions Communication and de-escalation skills	New mental health staff Medical staff Correctional officers	3 hours
ETHICS AND BEHAVIOR MANAGEMENT PRINCIPLES: Develop skill with applying ethical principles to the practice of behavior management with self-injurious inmates.	Increase understanding of the high level of risk involved in working with self-injurious inmates Increase appreciation of the importance for communicating and collaborating with the client in developing ethical behavior management interventions Increase sensitivity to the need for clinicians to adhere to very high ethical standards when engaged in behavior management with self-injurious inmates Learn seven ethical guidelines that are essential to behavior management Understand how these guidelines apply to practical applications of behavior management with self-injurious inmates	Mental health staff	2 hours
FUNCTIONAL ASSESSMENT IN BEHAVIOR MANAGEMENT: Develop skill in conducting functional assessments as the foundation for developing behavior management plans with self-injurious inmates.	Increase understanding of how behavior management interventions can be used to support behavioral change Enhance appreciation of the importance of intervening with controllable environmental events to effect behavioral change Develop appreciation for the importance of understanding and assessing the function of problem behaviors Learn the five major components of functional assessment Learn seven ”first principles” that are essential to functional assessment Learn how to define and describe problem behaviors effectively Learn how to identify environmental events that predict and maintain problem behaviors Learn how to develop hypotheses that summarize the functions of problem behaviors	Mental health staff	2-3 hours

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TITLE/GOAL OF TRAINING	OUTLINE OF TRAINING	RECOMMENDED PARTICIPANTS	ESTIMATED DURATION OF TRAINING
CLINICAL BOUNDARIES AND SAFE PRACTICES: Enhance understanding and awareness of clinical boundaries in the correctional setting and to promote safe practices to assure the safety of self and others in the workplace.	Role of the mental health professional working in corrections Working collaboratively and effectively with correctional personnel to enhance treatment and contribute to the safety and security of the facility Definition of clinical boundaries Transference and countertransference Inmate motives and examples of compromised professional ethics and personal/facility safety Recognizing inmate patterns and cues Skills and strategies to maintain boundaries and safety	New mental health staff Individual or group remedial or refresher training following an incident or issue concerning a breach of clinical boundaries or personal safety	2 hours
ADDRESSING SLEEP DISTURBANCE IN CORRECTIONAL SETTING: To provide a clinically-indicated systematic response that is evidence-based to appropriately respond to inmate sleep disturbance complaints.	Become familiar with diagnostic criteria for sleep disturbance Develop a consistent treatment response involving the inmate in the treatment Know signs that would trigger a psychiatry/medicine referral Become comfortable with the treatment protocol	Mental health staff	1 – 1.5 hours
TAKING A CHANCE ON CHANGE: PROGRAM FOR INMATES HOUSED IN SEGREGATION UNITS: REVISED MAY 2009 To introduce and explain the implementation of the Taking a Chance on Change Program to correctional officers, security supervisors and clinicians who work with inmates in segregation units	To increase understanding and knowledge of the segregation environment, the inmates in segregation and the potential mental health issues associated with segregation confinement. To review purpose/need for mental health segregation rounds. To introduce and understand how to implement the Taking a Chance on Change (TCC) program. To increase an understanding of the potential positive benefits to inmates and to the facility that can result from the TCC program	Corrections Department central office Wardens and Deputy Wardens Security supervisory staff Correctional officers Mental health staff	1-1.5 hours
CONDUCTING GROUPS IN CORRECTIONS: To increase understanding of the important role groups have in the mental health service delivery system. To become familiar with the basics of planning, organizing and conducting a therapy group.	Increase understanding of the importance of groups in serving the needs of our mental health population Recognizing groups as a modality that allows increased therapeutic involvement with inmates Become comfortable with process of planning, organizing and conducting groups Develop foundation for group leadership skills Includes: Why groups in corrections; Types of groups; Group leader's role and responsibilities; Effective group leader; Factors that impact group's effectiveness; Creating/planning a group; Selection of group members; Tips for a successful group; Starting the group; Skills for leader during group; Potential group problems and solutions; Common mistakes in leading groups; Stages in group development; Evaluation and documentation.	Mental health clinical staff	2.5- 3 hours

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TITLE/GOAL OF TRAINING	OUTLINE OF TRAINING	RECOMMENDED PARTICIPANTS	ESTIMATED DURATION OF TRAINING
HIPAA PRIVACY TRAINING-COMPREHENSIVE: Increase understanding of HIPAA privacy guidelines for staff required to have a comprehensive understanding of these guidelines and to prepare for conducting HIPAA Privacy Overview training.	Increased understanding of HIPAA's purpose Increase understanding of patient's access right Increase understanding of the levels of privacy Increase understanding of the handling and transmitting of information at various levels of privacy Increase understanding of variances permitted corrections under HIPAA *Given the complexity of the content of this training, the trainer's outline is supplemented with an outline of the PowerPoint presentation. This outline may be used as an additional handout to provide the trainees with HIPAA information after the training if the trainer chooses.*	This training provides a comprehensive review of HIPAA requirements that should be conducted with the administrative and clinical supervisors of each contract, to include the staff assigned responsibility for the Continuous Quality Improvement Program. Completion of this training is essential for staff responsible for conducting HIPAA Privacy Overview for all MMH staff in order to prepare to respond to trainee questions	2 hours
HIPAA PRIVACY OVERVIEW: Ensure understanding of HIPAA privacy guidelines that impact the sharing and handling of healthcare information, particularly information about individual inmates.	Increased understanding of HIPAA's purpose Increase understanding of HIPAA's Privacy Rule Increase understanding of variances permitted corrections under HIPAA Increase understanding of HIPAA guiding principles Increase understanding of the levels of privacy Increase understanding of how HIPAA effects the handling and transmitting of inmate-specific information *The HIPAA Privacy Overview training should be conducted by MHM staff who have completed the HIPPA Privacy Comprehensive Training.*	This training provides an overview of HIPAA requirements that should be completed when clinical and administrative staff join MHM and subsequently reviewed with all staff annually	1 hour
PRINCIPLES OF RISK ASSESSMENT: To introduce the role of risk assessment and provide an overview of the principles and purposes of assessing risks for dangerous behaviors in correctional populations.	Develop familiarity with the definition, scope and goals of risk assessment Increase understanding of the historical context and limitations of equating risk assessment exclusively with prediction Review improvements in risk assessment since 1970's Develop familiarity with actuarial and clinical approaches to risk assessment Introduce the structured clinical judgment approach to risk assessment Enhance skill in communicating risk assessment findings Familiarize trainees with risk reduction strategies	Training provides an introduction to role and principles of risk assessment. It does not provide training in how to utilize specific risk assessment instruments, and does not review all kinds of risk or all types of risk assessment technologies.	1½ to 2 hours

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TITLE/GOAL OF TRAINING	OUTLINE OF TRAINING	RECOMMENDED PARTICIPANTS	ESTIMATED DURATION OF TRAINING
MALINGERING AND THE M-FAST: To increase skill in screening and detecting malingering through formal psychometric assessment, using the M-FAST	Develop familiarity with the definition, suspicion criteria and prevalence of malingering Increase understanding of the range of assessment techniques utilized to assess malingering Develop familiarity with the Miller Forensic Assessment of Symptoms Test (M-FAST) Observe, score and interpret a practice case Begin considering management implications of a positive finding *This training is designed to be completed by licensed mental healt professionals who have professional training in diagnosis and psychometric assessment. Completion of this training requires access to a copy of M-FAST manual and training copies of the M-FAST interview booklets; these booklets should be collected at the end of the training session. Trainers and trainees participating in this module are responsible for maintaining the M-FAST test security. The trainer must have previous experience with the M-FAST in order to provide this training. Trainees will find completion of* Difficulties with Self-Report, Part 1: Deliberate Misrepresentatio *and* Difficulties with Self-Report, Part 2: Inadvertent Misrepresentation *helpful, prior to participating in this training module. Those two modules are found at the conclusion of the training series on diagnostic accuracy.*	Licensed mental health staff (psychologists, psychiatrists, and clinical social workers)	1 to 1.5 hours
THERAPEUTIC RESPONSE TO MALINGERING: To provide insight into the dynamics of malingering as well as provide a clinically indicated systematic response, that is evidence-based, to appropriately respond to inmates who have been found to malinger.	Become familiar with diagnostic criteria for malingering Develop a consistent treatment response involving the inmate in the treatment Become comfortable with a behavioral approach in responding to malingering *Trainees should be familiar with Malingering and the M-FAST module that are contained in the MHM staff training sections of the Clinical Operations Resource Manuals (if licensed mental health professionals) as well as the behavior management treatment planning module.*	Mental health staff	1 hour
SEX OFFENDER PROGRAMMING To gain an understanding of sexual offending, assessment of sexual recidivism risk, and sex offender treatment.	Introduce sexual disorders and common sexual offender typologies Familiarize trainees with static and dynamic risk assessment and the role of each in the treatment process Describe the components of a basic sex offender program Identify clinical boundary issues to manage when working with sex offenders	All staff working with sexual offenders in short-term corrections-based treatment programs	3-4 hours

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TRAINING SERIES ON TREATMENT PLANNING

TITLE/GOAL OF TRAINING	OUTLINE OF TRAINING	RECOMMENDED PARTICIPANTS	ESTIMATED DURATION OF TRAINING
CREATING A MULTIDISCIPLINARY TREATMENT PLAN: To increase skills in the development of clinically appropriate and realistic treatment plans	Increase understanding of purpose of treatment planning. Increase understanding of importance of multidisciplinary staff input into treatment planning. Increase understanding of components of a treatment plan.	Mental health staff	1 to 1.5 hours
TREATMENT GOALS AND INTERVENTIONS: To increase skills in the development of reasonable and measurable treatment plan goals, objectives, and interventions	Increase skill at creating and writing treatment goals and objectives Increase skill at defining and writing treatment plan interventions based on goals and objectives Increase familiarity with examples of goals, objectives, and interventions for common mental health problems in prison Practice writing goals and interventions	Mental health staff	1 to 1.5 hours
DOCUMENTING PROGRESS UNDER A TREATMENT PLAN: To increase skills in the proper documentation of treatment progress using the SOAP format	Increase understanding of the purpose of progress notes Increase skill at structuring a progress note to document treatment progress under a treatment plan Increase familiarity with common pitfalls and principles of progress note writing Practice writing progress notes using the SOAP format	Mental health staff	1 to 1.5 hours
REVIEWING AND UPDATING TREATMENT PLANS: To increase skills in reviewing and updating treatment plans	Increase understanding of the process of reviewing progress under a treatment plan Increase skill at updating problems and goals when clinically indicated during a treatment plan review Increase skill at updating treatment objectives based on progress or lack of progress Increase skill at updating interventions based on progress or lack of progress Practice updating a treatment plan	Mental health staff	1 to 1.5 hours
CREATING A CRISIS INTERVENTION TREATMENT PLAN: To increase skills in creating a crisis intervention treatment plan	Increase understanding of the need for a crisis intervention treatment plan Increase skill creating/updating crisis intervention plans Increase understanding of how a crisis effects the overall treatment plan	Mental health staff	1 to 1.5 hours
DOCUMENTING ON THE PROBLEM LIST: To increase skill at documenting problems on the inmate's master Problem List	Increase understanding of purpose of the Problem List. Increase accuracy of problems listed on the Problem List	Mental health staff	15 – 30 minutes

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TITLE/GOAL OF TRAINING	OUTLINE OF TRAINING	RECOMMENDED PARTICIPANTS	ESTIMATED DURATION OF TRAINING
INTRODUCTION TO CONTINUOUS QUALITY IMPROVEMENT: To enhance understanding and awareness of the Continuous Quality Improvement (CQI) process used to improve health care service delivery and to encourage staff participation in the CQI process.	Understanding CQI as a process of change and improvement Increased awareness of the steps in any CQI process Understanding the role of all staff in the CQI process	All new MHM staff	30-45 minutes
CONFIDENTIALITY IN CORRECTIONS: To provide staff with a background and understanding of confidentiality and the limits of confidentiality in correctional settings.	To increase understanding of confidentiality in a correctional setting To increase understanding of the limits of confidentiality in a correctional setting To provide rationale for the limits of confidentiality To increase understanding of situations when confidentiality cannot be not maintained To explain the process of responding to situations when confidentiality cannot be maintained	All clinical staff	45 minutes
MHM CREDENTIALING PROCESS: Increase understanding of rationale and procedures of MHM's initial and on-going credentialing process	To increase understanding of the rationale for the credentialing process To increase understanding of the various steps in the credentialing process and which staff members have responsibility for each of the steps To explain the process for the initial and on-going credentialing of physicians, psychiatrists, dentists, nurse practitioners and doctoral level psychologists To explain the process for the initial and on-going credentialing of masters level clinicians, nurses and non-licensed MHM staff To explain the purpose and how to implement the three files required for each MHM employee or contractor: Personnel File, Credential File and Confidential/Health & Safety File To reinforce the necessity to maintain accurate and current employee files To describe the type of databases required to monitor the status of staff credentials	Program Managers and Assistant Program Managers Regional Office Administrative Assistants CQI Managers MHM staff assigned to the Credentialing Review Panel	1.5-2 hours
STRUCTURING AND FORMATTING CONTINUOUS QUALITY IMPROVEMENT REPORTS To assist participants in understanding the CQI report format with the goal of increasing the consistency of communicating study processes and findings across contracts.	Review of Study Topic Selection The Study Introduction Documenting Study Methods Presenting Study Finding Study Discussion	CQI Managers Supervisory staff	45 minutes

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TITLE/GOAL OF TRAINING	OUTLINE OF TRAINING	RECOMMENDED PARTICIPANTS	ESTIMATED DURATION OF TRAINING
INTRODUCTION TO PRISON RAPE ELIMINATION ACT: Increase understanding of the expectations of the Prison Rape Elimination Act of 2003 for mental health staff working in a correctional setting	To increase understanding of the goals of Prison Rape Elimination Act of 2003 (PREA) To increase understanding of the role of the National Prison Rape Elimination Commission (NPREC) To review general expectations of NPREC Standards To review expectations of the NPREC Standards for mental health staff	All MHM staff Correctional staff	30 minutes
PREA SENSITIVITY TRAINING: To increase competency, sensitivity and effectiveness in assessing and delivering acute care to inmates who allegedly have been victims of sexual assault.	Training Requirements under PREA Crisis Intervention Impact of Victimization Assessment of Impact Treatment Interventions– Brief Overview	Mental health staff	1 ½ hours
HEALTH RECORD DOCUMENTATION To review good documentation practices and increase skill using SOAP(E) format.	Define value of health record documentation Describe elements of good documentation practices Discuss common documentation pitfalls Describe the purpose of progress notes Use SOAP(E) to document patient encounters	Medical staff including physicians, nurse practitioners, physician assistants, nurses Mental health staff including psychiatrists, nurse practitioners, Mental health professionals and nurses	1 hour
WORKING WITH INCARCERATED WOMEN: To increase knowledge of the criminal, social and mental health issues of women incarcerated in correctional environments and understand effective communication and treatment techniques.	Characteristics of Incarcerated Women Substance Abuse, Health & Mental Health Impact of Trauma How Women Do Time Effective Communication & Treatment Approaches	Mental health staff Medical staff	4 hours
TRAUMA TREATMENT: PART 1 - POST TRAUMATIC STRESS DISORDER AND COMPLEX POST TRAUMATIC STRESS DISORDER: To become familiar with the nature of Post Traumatic Stress Disorder and Complex Post Traumatic Stress Disorder and to understand how these concepts impact diagnosis and treatment in correctional populations *This training provides an introduction to PTSD and Complex PTSD. It is intended for mental health staff and is the first of a three-part series*	Review the specific diagnostic criteria and symptom clusters for PTSD Increase understanding of the frequency of PTSD and the nature of stressors that can trigger PTSD Become familiar with the benefits and drawbacks of the PTSD diagnosis as it is currently understood in the *DSM-IV* Develop familiarity with the relationships between PTSD and both Borderline Personality Disorder and Antisocial Personality Disorder Review the diagnostic criteria for "Complex" PTSD and their relationship with personality disorders Become familiar with the relationship between PTSD and	Mental health staff	1 ½ - 2 hours

TITLE/GOAL OF TRAINING	OUTLINE OF TRAINING	RECOMMENDED PARTICIPANTS	ESTIMATED DURATION OF TRAINING
on trauma and treatment in correctional environments. Parts two and three cover trauma-informed treatment and gender-responsive trauma-informed treatment, respectively. A separate training on Working with Incarcerated Women is available for correctional, medical and mental health staff.	Complex PTSD Familiarize trainees with treatment implications		
TRAUMA TREATMENT PART II: TRAUMA-INFORMED To become familiar with the nature of trauma treatment and trauma-informed treatment and to understand how trauma-informed treatment is the preferred modality in correctional populations.	Review the nature of PTSD symptoms and classification of PTSD as an Anxiety Disorder Increase understanding of the symptom course of PTSD and implications of this course for treatment Become familiar with the impact of trauma for inmate populations Develop familiarity with the three phases of trauma treatment Understand the goals and interventions for each phase of trauma treatment Learn to distinguish between trauma-informed treatment and trauma treatment Sensitize trainees to the risks of trauma treatment and need to provide supportive rather than "uncovering" interventions for trauma victims	Mental health staff	1 ½ - 2 hours
TRAUMA TREATMENT PART III: GENDER-RESPONSIVE TREATMENT: To become familiar with the need for and nature of gender-responsive treatment and to understand how this model impacts trauma-informed treatment in correctional populations. *This training is the third of a three-part series on trauma and treatment in correctional environments. Parts one and two cover PTSD/Complex PTSD and trauma-informed treatment, respectively. Parts one and two should be provided prior to the current module because this module builds on the first two.*	Provide a brief review of the three-phase model of trauma treatment Increase understanding of gender differences in the prevalence and type of trauma Increase understanding of gender differences in the prevalence and symptoms of PTSD Develop familiarity with the relationships among trauma, addictive behaviors and incarceration in female offenders Become familiar with the core elements and guiding principles of gender-responsive treatment environments Understand how trauma-informed treatment must be adjusted to be gender-responsive when working with female offenders Familiarize trainees with guidelines and resources for providing gender-responsive trauma-informed treatment	Mental health staff	1 ½ - 2 hours

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TITLE/GOAL OF TRAINING	OUTLINE OF TRAINING	RECOMMENDED PARTICIPANTS	ESTIMATED DURATION OF TRAINING
THERAPEUTIC RESTRAINTS: INITIAL CREDENTIALLING To provide mental health staff with the skills necessary to minimize the use of therapeutic restraints and to implement therapeutic restraints in a safe manner when they are necessary. Training Objectives Understand the difference between therapeutic and custody restraints Understand the risks, benefits and goals of utilizing therapeutic restraints Develop familiarity with the legal and ethical context for mental health restraints Enhance competence in identifying triggers to behavioral crises Enhance competence in utilizing non-physical de-escalation skills Learn to select the least restrictive interventions based on an individualized assessment of the inmate's medical, mental health and behavioral status Become familiar with special physical and mental health conditions that may contraindicate use of therapeutic restraints Develop working familiarity with the application and use of therapeutic restraints Become competent in monitoring the physical and psychological well-being of an inmate who is being restrained, including recognizing and responding to signs of physical and psychological distress in inmates who are restrained Develop skill in identifying the specific behavioral changes which indicate that therapeutic restraints are no longer needed, and minimizing the duration of restraints Become competent in debriefing inmates following a restraint episode Become competent in developing/revising individualized treatment plans for inmates who require therapeutic restraints	*This initial training covers key elements required to credential staff in the use of therapeutic restraints. Competency in minimizing the use of therapeutic restraints; in the application of restraints; in monitoring, assessment, and providing care for an inmate in therapeutic restraints; and in discontinuing therapeutic restraints is required before staff participate in the use of such restraints. The training is designed for mental health and medical staff who provide services where therapeutic restraints are likely to be used. However, correctional staff assigned to these locations will also benefit from this training. Provision of this training in a multidisciplinary session is recommended. Most correctional systems provide staff training in the application of restraints. The training offered in this module is meant to supplement, rather than replace, your DOC/ Jail training. This module focuses on mental health and medical staff responsibilities during the use of restraints, on the use of restraints as a safety intervention, and on how to determine when an inmate needs to go in or come out of therapeutic restraints. This training module does not address "how to" restraint and documentation procedures, which are covered in your DOC/ Jail training. Annual "refresher" staff training is provided in a separate MHM training module. This training does include opportunity for a hands-on practice session in which trainees volunteer to be "inmates" and are placed in restraints by other trainees. Because therapeutic restraints are typically applied by correctional officers, it is important to have sufficient officer presence to conduct this component of the training. The trainer should be prepared to oversee this practice session, including arranging (in advance) access to restraints and a restraint bed/chair. It may be necessary to hold the training at the correctional training academy. The training module provides training sufficient to meet the standards set out in MHM's Model Policy and Procedures for the Use of Therapeutic Restraints in Correctional Facilities, the requirements set out in related NCCHC and ACA standards, and the guidelines provided by the American Psychiatric Association's Council on Psychiatry and Law. Prior to providing this course, instructors must be familiar with, and prepared to explain, any specific DOC/Jail regulations, policies or directives related to the use of restraints for mental health purposes. Copies of the DOC policies and procedures relevant to therapeutic restraints should be provided to trainees at the outset of this training.*	Mental health, medical and correctional staff	3 – 4 hours

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TITLE/GOAL OF TRAINING	OUTLINE OF TRAINING	RECOMMENDED PARTICIPANTS	ESTIMATED DURATION OF TRAINING
VIOLENCE RISK ASSESSMENT - PART 1: To introduce the role of violence risk assessment and provide an overview of the research literature on this topic.	Develop familiarity with definition, scope, goals of risk assessment Increase understanding of the historical context and limitations of equating risk assessment exclusively with prediction Review improvements in risk assessment since the 1970's Develop familiarity with actuarial and clinical approaches to risk assessment Introduce the structured clinical judgment approach to risk assessment Enhance skill in communicating risk assessment findings Familiarize trainees with common risk reduction strategies Provide an interactive training that closes with a group discussion of a clinical case	Mental health staff	2 ½ - 3 hours
VIOLENCE RISK ASSESSMENT TRAINING - PART II - PRISON VIOLENCE: To introduce the role of violence risk assessment within correctional facilities and provide an overvie of the research literature on this topic.	Develop familiarity with definition, scope, goals of risk assessment Review risk factors for violence within correctional settings Develop familiarity with approaches to risk assessment within correctional settings Enhance skill in communicating risk assessment findings Familiarize trainees with frequently needed risk reduction strategies Differentiate between types of risk issues and treatment strategies designed to address these different types of risk issues in correctior facilities Provide an interactive training with clinical case presentations throughout the presentation	Mental health staff	2 ½ - 3 hours
VIOLENCE RISK ASSESSMENT: ROLE OF CORRECTIONAL OFFICERS: To introduce the role of risk assessment, to review risk factors and warning signs for violent and dangerous behaviors in correctional populations, and to discuss risk management techniques. *This training provides an introduction to the role and principles of risk assessment for correctional staff. It does not provide training in how to utilize specific risk assessment instruments and does not review all forms of risk or all types of risk assessment technologies. The focus of this training is the identification of warning signs for potential violence among incarcerated offenders and how correctional staff should communicate this information to supervisors and mental health staff.*	Develop familiarity with the definition, scope and goals of risk assessment Increase understanding of the risk factors and warning signs for violent behavior Enhance skill in communicating observations Familiarize trainees with frequently needed risk management strategies	Correctional staff Mental health staff	2 ½ - 3 hours

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STAFF/MANAGEMENT DEVELOPMENT

TITLE/GOAL OF TRAINING	OUTLINE OF TRAINING	RECOMMENDED PARTICIPANTS	ESTIMATED DURATION OF TRAINING
PRINCIPLES OF LEADERSHIP: Increase understanding of leadership principles than can significantly impact effectiveness in management and supervisory roles	To increase understanding of the meaning of positive leadership To increase understanding of the meaning of positive "followership" To provide a historical review of leadership styles To review the basic dynamics of successful leadership To review issues that challenge effective leadership	Site Administrators Supervising Mental Health Professionals Program Managers and Assistant Program Managers Medical Directors and CQI Managers	11/2 – 2 hours
PRINCIPLES OF MANAGEMENT Increase understanding of management principles than can significantly and positively impact effectiveness in management and supervisory roles	To address dynamics related to the maximizing the effectiveness of staff To address dynamics related to the maximizing the productivity of the work environment To increase understanding of the meaning of positive reinforcement To review the basic elements of successful performance evaluation To review issues that challenge effective corrective action	Site Administrators Supervising Mental Health Professionals Program Managers and Assistant Program Managers Medical Directors and CQI Managers	1 hour

INDEX TO STAFF TRAINING MODULES: DIAGNOSTIC TRAINING SERIES

(Effective April 2008)

Twenty-five 1 to 1.5 hour training modules designed to be conducted at staff meetings to increase staff understanding of the diagnostic process and to improve accuracy in making diagnoses. Modules should be completed in sequence whenever possible. Content of modules varies in complexity. Modules 16 through 23 may be best presented to experienced mental health staff, psychologists and psychiatrist. Modules 24 and 25 are important for all mental health staff. It is essential that the trainer is familiar with the content before attempting to conduct training using these modules.

TITLE/GOAL OF TRAINING	OUTLINE OF TRAINING	RECOMMENDED PARTICIPANTS	ESTIMATED DURATION OF TRAINING
MODULE 1: THE BASICS – WHAT IS A DIAGNOSIS? To begin laying foundation for making accurate mental health diagnosis by providing basic definitions for diagnosis and concepts related to making a diagnosis.	Increase understanding of what a diagnosis is Increase understanding of terms related to making a diagnosis (i.e., symptom, sign, episode) Increase skills in recognizing signs, symptoms, and episodes Increase understanding of the value of a diagnosis	Mental health staff	1 hour
MODULE 2: THE BASICS – DIAGNOSTIC SYSTEM To increase understanding of the purpose and application of the five diagnostic axes recognized by the American Psychiatric Association	Increase understanding of the purpose of the Diagnostic and Statistical Manual of Mental Disorders (DSM) Increase understanding of the five axes of DSM diagnoses Increase skills in using info provided by DSM multi-axial diagnoses Increase understanding of how to distinguish between Axis I and Axis II presentations	Mental health staff	1 hour
MODULE 3: THE PROCESS – MENTAL STATUS EXAM To increase skill in conducting and analyzing a mental status exam and determining its utility in making a diagnosis	Increase knowledge of domains of thorough mental status exam Increase skill in conducting a mental status exam Increase understanding of the role of an MSE in diagnosing mental disorders Learn 3 methods to assess mental status Understand how to use information from a mental status when making hypotheses about diagnoses	Mental health staff	1 to 1.5 hours
MODULE 4: DIAGNOSIS AND BASE RATES Increase awareness of base rates of mental disorders in jails and prisons, and how to use base rate information when diagnosing mental disorders	Learn four factors contributing to increased prevalence of mental disorders in jails/prisons, over community base rates Become familiar with the base rates of seven Axis I disorders in prisons and jails, and how these compare with base rates for the same disorders in the community Become familiar with the base rates of two Axis II disorders in prisons and jails, and how these compare with base rates for the same disorders in the community Increase awareness of and appreciation for consequences of base-rate realities Develop understanding of how base rate information can inform diagnostic inquiries	Mental health staff	1 to 1.5 hours

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MODULE 5: GLOBAL ASSESSMENT OF FUNCTIONING (GAF) Increase familiarity with the Global Assessment of Functioning (GAF) scale and how to use it accurately when diagnosing mental disorders.	Develop familiarity with the assessment of global functioning Learn to distinguish between functional impairments and symptoms Increase sensitivity to considering both functional impairment and symptoms when assigning GAF scores Develop familiarity with GAF scale characteristics and practice guidelines for using the GAF Learn the 10-point ranges in the GAF and the four steps for assigning a GAF rating Practice scoring two vignettes Become familiar with the GAF's reliability and measurement error Understand the implications of the GAF for diagnostic practice and future developments	Mental health staff	1 to 1.5 hours
MODULE 6: DIAGNOSTIC HYPOTHESIZING-GROUNDWORK To increase understanding of the foundation for the process of hypothesizing about diagnoses in order to increase skill at making accurate diagnoses.	Increase understanding of how a diagnosis is made Learn steps to narrow the list of possible diagnoses Increase skills in using diagnostic specifiers and progress notes to clarify diagnoses Decrease need for NOS diagnoses General criteria used in diagnostics Steps to narrow the diagnostic field Using specifiers to clarify clinical presentation Using progress notes as communication tools regarding diagnoses	Mental health staff	1 to 1.5 hours
MODULE 7: DIAGNOSTIC HYPOTHESIZING – AXIS I To increase skill at making hypotheses about Axis I disorders and to move toward assigning diagnoses.	Increase understanding of the core features of Axis I disorders Increase skills in recognizing and utilizing core features to make diagnostic hypotheses Core characteristics of the most common Axis I disorders Interviewing for core characteristics Making diagnostic hypotheses – Case Example	Mental health staff	1 to 1.5 hours
MODULE 8: DIAGNOSTIC HYPOTHESIZING—AXIS II To increase skill at diagnosing personality disorders generally and differentiating among four common personality disorders specifically	Increase understanding of the common features of personality disorders Increase skills in recognizing and utilizing differentiating characteristics to make diagnostic hypotheses among four common personality disorders Increase awareness of overlap among common personality disorders Practice assigning diagnoses to personality trait constellations	Mental health staff	2 to 2.5 hours

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TITLE/GOAL OF TRAINING	OUTLINE OF TRAINING	RECOMMENDED PARTICIPANTS	ESTIMATED DURATION OF TRAINING
MODULE 9: DIFFERENTIATING AMONG PSYCHOTIC DISORDERS To increase skill at differentiating among the psychotic disorders and making an accurate diagnosis	Increase understanding of the common features of psychotic disorders Increase skills in recognizing and utilizing differentiating characteristics to make diagnostic hypotheses among the most common psychotic disorders Practice assigning diagnoses to psychotic symptom constellations	Mental health staff	1 to 1.5 hours
MODULE 10: DIFFERENTIATING AMONG PSYCHOSIS AND POST TRAUMATIC STRESS DISORDER To increase skill at differentiating between psychotic disorders and Posttraumatic Stress Disorder	Increase understanding of the common features of psychotic disorders and PTSD Increase skills in recognizing and utilizing differentiating characteristics to make diagnostic hypotheses Practice assigning diagnoses	Mental health staff	1 to 1.5 hours
MODULE 11: DIFFERENTIATING BETWEEN BIPOLAR DISORDERS AND BORDERLINE PERSONALITY DISORDER To increase skill at diagnosing Bipolar Disorders and differentiating between Bipolar Disorders and Borderline Personality Disorder	Develop familiarity with the diagnostic criteria for each type of mood episode Increase understanding of the core characteristics and diagnostic requirements for Bipolar Disorders Increase familiarity with the rates of co-morbidity between Bipolar Disorders and Borderline Personality Disorder Increase appreciation for the relative base rates for Bipolar Disorders and Borderline Personality Disorder Increase awareness of overlapping features among Bipolar Disorders and Borderline Personality Disorder Increase awareness of the differentiating features among Bipolar Disorders and Borderline Personality Disorder, and how to elicit these in an interview Practice differentiating these diagnoses with a case example	Mental health staff	1 to 1.5 hours
MODULE 12: DIFFERENTIATING ADJUSTMENT DISORDERS FROM OTHER PSYCHIATRIC CONDITIONS To increase skill at differentiating Adjustment Disorders from other psychiatric conditions	Increase understanding of the diagnostic criteria of Adjustment Disorders Increase skills in recognizing differentiating features of Adjustment Disorders versus features of other psychiatric conditions Identify that suicide risk accompanies Adjustment Disorders Practice assigning diagnoses	Mental health staff	1 to 1.5 hours

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TITLE/GOAL OF TRAINING	OUTLINE OF TRAINING	RECOMMENDED PARTICIPANTS	ESTIMATED DURATION OF TRAINING
MODULE 13: CO-OCCURRING DISORDERS: SUBSTANCE RELATED DISORDERS AND MENTAL ILLNESS To increase skill at identifying co-occurring Substance Related Disorders and estimating their impact on functioning	Increase understanding of the diagnostic criteria of Substance Related Disorders including Substance Use and Substance Induced Disorders Increase knowledge related to co-occurring Substance Related Disorders among other psychiatric conditions Practice identifying substance use disorders as co-occurring disorders	Mental health staff	1 hour
MODULE 14: DIAGNOSTIC IMPLICATIONS OF ACQUIRED BRAIN DAMAGE To increase skill at detecting the clinical and diagnostic implications of acquired brain damage.	Develop familiarity with the sources and prevalence of acquired brain damage Increase understanding of the consequences of Traumatic Brain Injuries (TBIs) Increase skills in diagnosing Personality Change Due to Acquired Brain Damage Increase skills differentiating between Axis I Personality Changes and Axis II Personality Disorders Develop familiarity with increased risk for mental illness following TBIs Practice differentiating Personality Changes from other Axis I and Axis II diagnoses, using a case example	Mental health staff	1 to 1.5 hours
MODULE 15: DIAGNOSING ATTENTION DEFICIT/HYPERACTIVITY DISORDER ACCURATELY To increase skill at diagnosing Attention Deficit/Hyperactivity Disorder (ADHD) accurately and differentiating between ADHD and Bipolar Disorders.	Develop familiarity with the core characteristics and diagnostic criteria for ADHD Increase understanding of the three subtypes of ADHD Increase appreciation for the base rates for ADHD Increase skills in sequential decisions required for diagnosing ADHD Increase awareness of implications and consequences of diagnosing ADHD Increase awareness of co-morbidity, distinguishing and overlapping features among ADHD and Bipolar Disorders Practice differentiating these diagnoses with a case example	Mental health staff	1 to 1.5 hours

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TITLE/GOAL OF TRAINING	OUTLINE OF TRAINING	RECOMMENDED PARTICIPANTS	ESTIMATED DURATION OF TRAINING
MODULE 16: THE "COGNITIVE AUTOPSY" AND DIAGNOSTIC OVERSHADOWING To become familiar with the process of conducting a "cognitive autopsy" when diagnostic errors are identified, and to learn how diagnostic overshadowing can lead to significant diagnostic errors, in order to decrease such errors.	Become familiar with the frequency of diagnostic errors Learn three categories of diagnostic error sources Develop recognition that cognitive biases and errors are important contributors to diagnostic error Learn the basic principles of conducting a "cognitive autopsy" once a diagnostic error is identified Develop skill in identifying diagnostic overshadowing and how it can influence diagnostic decision-making Learn when diagnostic overshadowing is most likely to occur Learn how to counteract diagnostic overshadowing when forming diagnostic hypotheses	Experienced mental health staff, psychologists, psychiatrists	1 to 1.5 hours
MODULE 17: DIAGNOSING UNDER CONDITIONS OF UNCERTAINTY, PART I Introduce study of diagnostic decision-making and cognitive biases, called Cognitive Dispositions to Respond (CDRs), in order to learn how to decrease diagnostic errors	Understand the difference between traditional and process-oriented approaches to diagnostic training Understand the multiple factors that contribute to conditions of uncertainty when diagnoses are being made Heighten sensitivity to the haste with which diagnostic impressions are formed Introduce the study of diagnostic thinking using a case study Enhance awareness of the pervasiveness of cognitive biases in diagnostic decision-making Gain familiarity with Cognitive Dispositions to Respond (CDRs)	Experienced mental health staff, psychologists, psychiatrists	1 to 1.5 hours
MODULE 18: DIAGNOSING UNDER CONDITIONS OF UNCERTAINTY, PART 2 To recognize and counteract two diagnostic biases, called "anchoring with insufficient adjustment" and "availability," in order to decrease diagnostic errors	Briefly review process approach to diagnostic training and Cognitive Dispositions to Respond (CDRs) Develop skill in identifying the nature of the CDR "anchoring with insufficient adjustment" and how it can influence diagnostic decision-making Develop skill in identifying the nature of the CDR "availability bias" and how it can influence diagnostic decision-making Learn how anchoring and availability can operate together Learn how to counteract anchoring and availability when forming diagnostic impressions	Experienced mental health staff, psychologists, psychiatrists	1 to 1.5 hours
MODULE 19: DIAGNOSING UNDER CONDITIONS OF UNCERTAINTY, PART 3 To recognize and counteract two diagnostic biases – representativeness restraint and confirmation bias – in order to decrease diagnostic errors	Briefly review process approach to diagnostic training and Cognitive Dispositions to Respond (CDRs) Develop skill in identifying the nature of representativeness restraint and how it can influence diagnostic decision-making Develop skill in identifying the nature of confirmation bias and how it can influence diagnostic decision-making Learn the adaptive and reinforcing nature of representativeness restraint and confirmation bias	Experienced mental health staff, psychologists, psychiatrists	1 to 1.5 hours

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TITLE/GOAL OF TRAINING	OUTLINE OF TRAINING	RECOMMENDED PARTICIPANTS	ESTIMATED DURATION OF TRAINING
MODULE 20: DIAGNOSING UNDER CONDITIONS OF UNCERTAINTY, PART 4 To recognize and counteract two diagnostic biases – commission and omission biases – in order to decrease diagnostic errors	Briefly review process approach to diagnostic training and Cognitive Dispositions to Respond (CDRs) Develop skill in identifying the nature of commission bias and how it can influence diagnostic decision-making Develop skill in identifying the nature of omission bias and how it can influence diagnostic decision-making Learn the adaptive and reinforcing nature of commission and omission biases Learn how to counteract commission and omission biases when forming diagnostic impressions	Experienced mental health staff, psychologists, psychiatrists	1 to 1.5 hours
MODULE 21: DIAGNOSING UNDER CONDITIONS OF UNCERTAINTY, PART 5 To recognize and counteract two diagnostic biase – diagnostic momentum and search satisfaction (also called premature closures) – in order to decrease diagnostic errors	Briefly review process approach to diagnostic training and Cognitive Dispositions to Respond (CDRs) Develop skill in identifying the nature of diagnostic momentum and how it can influence diagnostic decision-making Develop skill in identifying the nature of search satisfaction/premature closure and how it can influence diagnostic decision-making Learn the adaptive and reinforcing nature of diagnostic momentum and search satisfaction/premature closure Learn to counteract diagnostic momentum and search satisfaction/premature closure when forming diagnosis	Experienced mental health staff, psychologists, psychiatrists	1 to 1.5 hours
MODULE 22: DIAGNOSING UNDER CONDITIONS OF UNCERTAINTY, PART 6: To recognize and counteract two diagnostic biase – thinking in silos and feedback sanction – in orde to decrease diagnostic errors	Briefly review process approach to diagnostic training and Cognitive Dispositions to Respond (CDRs) Develop skill in identifying the nature of thinking in silos and how it can influence diagnostic decision-making Develop skill in identifying the nature of feedback sanction and how it can influence diagnostic decision-making Learn the adaptive and reinforcing nature of thinking in silos and feedback sanction Learn how to counteract thinking in silos and feedback sanction when forming diagnostic impressions	Experienced mental health staff, psychologists, psychiatrists	1 to 1.5 hours
MODULE 23: DIAGNOSING UNDER CONDITIONS OF UNCERTAINTY, PART 7 To recognize and counteract one more diagnostic bias – overconfidence – and to summarize the diagnostic biases from this series, in order to decrease diagnostic errors	Briefly review process approach to diagnostic training and Cognitive Dispositions to Respond (CDRs) Develop skill in identifying the nature of overconfidence bias and how it can influence diagnostic decision-making Learn adaptive and reinforcing nature of overconfidence bias Learn how to counteract overconfidence bias when forming diagnostic impressions Review the 11 CDRs that have been studied in this series	Experienced mental health staff, psychologists, psychiatrists	1 to 1.5 hours

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TITLE/GOAL OF TRAINING	OUTLINE OF TRAINING	RECOMMENDED PARTICIPANTS	ESTIMATED DURATION OF TRAINING
MODULE 24: DIFFICULTIES WITH SELF-REPORTS, PART 1: DELIBERATE MISREPRESENTATION To become familiar with patterns of deliberate misrepresentation in inmate self-reports in order to decrease diagnostic errors	Briefly overview three sources of diagnostic error: systemic sources, clinician-generated sources, and inmate-generated sources Develop understanding of the nature, possible motivations, and difficulties in detecting or "diagnosing" Deliberate Denial Develop understanding of the nature, possible motivations, and difficulties in diagnosing Factitious Disorder Develop understanding of the nature, possible motivations, and difficulties in diagnosing Malingering Enhance appreciation for relationships among deliberate misrepresentations, mental illnesses, behavioral risks, and threats to diagnostic accuracy Develop skills in assessing credibility of self-report, utilizing multiple sources to diagnose mental illness, and clarifying discrepancies when deliberate misrepresentation is suspected	Mental health staff	1 to 1.5 hours
MODULE 25: DIFFICULTIES WITH SELF-REPORTS, PART 2: INADVERTENT MISREPRESENTATION To become familiar with patterns of inadvertent misrepresentation in inmate self-reports in order to decrease diagnostic errors	Briefly overview three sources of error in self-reports: deliberate misrepresentation, inadvertent misrepresentation, and situational factors Develop understanding of the nature and common indicators for six sources of inadvertent misrepresentation in inmate self-reports Learn how these six sources are associated with under- and over-reporting of symptoms Learn how these sources of inadvertent misrepresentation are associated with mental disorders Enhance appreciation for relationships among deliberate (intentional) misrepresentations, inadvertent (non-intentional) misrepresentations, situational factors, and threats to diagnostic accuracy Develop skills in assessing credibility of self-report, utilizing multiple sources to diagnose mental illness, and clarifying discrepancies when inadvertent misrepresentation is suspected	Mental health staff	1 to 1.5 hours

MHM CREDENTIALING PROCESS

As a provider of mental health services, MHM uses its best efforts to ensure that individuals recruited to provide clinical services in correctional facilities have the appropriate training and credentials to perform these services. Documentation establishes that reported licenses and credentials have been verified and that licenses/credentials remain current.

While specific contracts may require more extensive credentialing, the MHM Credentialing Process establishes the Company's process. The MHM Credentialing Process is consistent with the standards of the National Commission on Correctional Health Care (NCCHC) and the American Correctional Association (ACA).

MHM Policy:
All MHM mental health, medical and dental staff members must provide confirmation of compliance with the licensure, registration, education, and professional standards of the community and be in full compliance with state statutes and health care regulations including professional boards and other regulatory bodies. All staff authorized to prescribe medications must have current individual Drug Enforcement Agency (DEA) registration numbers (state and federal where applicable).

Credentials are verified during the recruiting and hiring process based upon primary sources and recognized registries. When licenses are renewed, the verification of licensure is repeated. For staff prescribing medication, dentists and doctoral level licensed psychologists, the National Practitioner Data Bank (NPDB) is reviewed annually to ensure that the staff member remains in good standing.

MHM maintains copies or verification of current licensing, certification, and registration information in staff-specific Credential Files in accordance with NCCHC and ACA standards and in compliance with contractual requirements. Credential Files will be maintained at the contract's Regional Office unless the client requests that the files are also available on-site. Credential Files are provided to the sites when required by NCCHC, ACA or authorized agency audits.

The contract's Program Manager has overall responsibility to ensure appropriate completion of the credentialing process and maintenance of updated Credential Files. Credential verification is completed by a credentialing agency and/or MHM staff who have received training in the credentialing process. The CQI Manager is responsible to conduct semi-annual audits of the Credential Files to ensure that all information has been updated as necessary.

Job Descriptions

1. Job descriptions are developed to ensure that all MHM staff are aware of the tasks, duties and responsibilities of their assigned positions including performance objectives and reporting requirements, and hold the prerequisite credentials and licenses. Job descriptions are used in the orientation of the staff member and in the on-going monitoring of job performance. Job descriptions provide the framework for annual performance evaluations.

2. Job descriptions are developed for each staff position in a contract as part of proposal development and/or during the contract implementation period.

3. Job descriptions include an overview of the position, job responsibilities and tasks, credentialing requirements, and other required skills and capabilities. All job descriptions are developed in a manner consistent with Federal and State laws, including the American with Disabilities Act.

3. For clinical staff, job descriptions include requirement that staff member will be an active participant in the Continuous Quality Improvement program, including peer review.

4. Job descriptions for a specific contract may be required to be submitted to the client for approval prior to implementation.

5. MHM staff member will be expected to sign the relevant job description prior to assuming job duties.

6. The signed job description will be filed in the staff member's Credential File with a copy sent to MHM's Human Resources Department, a copy filed in the Personnel File, and a copy given to the staff member. The copy sent to Human Resources should highlight the five major job responsibilities on which the staff member's performance will be evaluated.

7. Job descriptions should be revised when job expectations and responsibilities change.

MHM Staff Responsibilities

1. Each MHM clinician is responsible for maintaining a current license, certification, registration, or other credentials specified by the MHM position description and required by the jurisdiction in which direct care is provided.

2. Each mental health staff member is responsible for maintaining the additional certifications required by the client agency.

3. During the hiring process, candidates for mental health staff positions are responsible for presenting proof of credentials that satisfy job description and contract requirements. Candidates are expected to report any existing restrictions on their licenses.

4. Consent for the release of information to permit verification of credentials is included in the MHM letter offering employment. The consent for the release of information must be completed by all candidates for MHM positions. Applicants are informed that employment with MHM is contingent on results of the credential verification.

5. Upon hire, mental health staff are responsible for signing the job description that outlines the responsibilities and duties of the position as well as the credentials expected for staff assuming these responsibilities.

6. MHM staff are responsible for providing the Program Manager or designee documentation that required licenses and certifications have been renewed prior to their expiration. Staff who do not submit the documentation of license and certification renewals will be suspended without pay until the documentation is provided.

7. MHM staff are responsible for informing the Program Manager of any pending actions that might jeopardize licensure or certification immediately upon notification of the actions.

8. MHM staff are responsible for notifying the Program Manager immediately if any change in their license status occurs, including but not limited to restrictions, revocation, probation or limit on provider privileges.

9. In some contracts, MHM staff are responsible for providing documentation to the Program Manager or designee confirming completion of Continuing Medical Education (CME) or Continuing Education Unit (CEU) training required to maintain licensure.

MHM Administrative Staff Responsibilities

1. The contract's Program Manager is responsible to know the credentialing requirements of the specific contract. Some clients require periodic updates to the initial credentialing information that they are provided.

2. The Program Manager is responsible to review the MHM credentialing process prospectively with client agencies for approval to ensure the process is consistent with state and local practice and contract requirements.

3. The contract's Program Manager has overall responsibility to ensure appropriate completion of the credentialing process and maintenance of updated Credential Files.

4. Initial verification of the credentials for physicians, nurse practitioners, physician assistants, dentists and licensed doctoral level psychologists is completed by MHM recruiters by accessing the National Practitioner Data Bank (NPDB). The NPDB is a national central repository of information on malpractice payments or other adverse licensure actions. When the Program Manager submits a request for an offer letter, he/she is confirming that a NPDB report was requested, received and provided no information precluding employment of the applicant with MHM. Although offer of employment letters can be initiated prior to the completion of the NPDB review and credentialing process, offer letters must state that employment is conditioned on successful completion of the NPDB and credentialing review process.

5. MHM's Clinical Operations Department is responsible to review NPDB reports that include any indication of issues in that past. In cases in which the initial review by Clinical Operations indicates there is potential significant concern, the case will be forwarded to MHM's Credentialing Review Committee. Further information regarding negative information in the NPDB report may be requested from MHM's legal support.

6. The MHM Credentialing Review Committee reviews the information about a case and determines if the concern precludes employment of the individual by MHM. Operations of the MHM Credentialing Committee are governed by the By-Laws attached to this protocol.

7. The Program Manager will consult with the client whenever hiring an employee whose NPDB report includes negative information. For all candidates, in-depth credential verification is completed for physicians, nurse practitioners, physician assistants, dentists and licensed doctoral level psychologists by a credentialing agency. The credentialing agency will assist with the initial primary source verification of licensure; certification; registration; education; and/or other credentials specified by the MHM job description and required by the jurisdiction.

8. Licensure verifications for other staff are completed by Regional Office MHM staff who have received training in the credentialing process.

9. The Program Manager is responsible to assign the preparation of three files for all new staff: the Employee File, the Credential File, and the Health and Safety File. The required contents for these files are described below.

10. An NPDB inquiry will be completed annually by the contracted credentialing agency for all physicians, nurse practitioners, physician assistants, dentists, and licensed doctoral level psychologists working in each contract. These inquiries will be completed each year during the month of the contract's anniversary date.

11. MHM's Clinical Operations Department is responsible for reviewing the results of the annual NPDB inquiries if there are any concerns. In cases in which Clinical Operations staff judge there may be a potential significant concern, legal and management staff will be advised of the concern.

12. The CQI Manager is responsible to conduct periodic audits, no less than semi-annually, of the Credential Files to ensure that all information has been updated as necessary.

13. The MHM Clinical Operations Department is responsible for conducting audits of the Credential Files during annual contract compliance reviews.

Credentialing Process for Physicians, Nurse Practitioners, Physician Assistants, Dentists and Licensed Doctoral Level Psychologists

1. During the recruitment process and prior to making an oral or written job offer, the recruiter will initiate an NPDB inquiry. The recruiter will obtain the information necessary for an NPDB inquiry from the applicant candidate which includes:
    - Full Name
    - Date of Birth
    - Social Security Number
    - Permanent Home Address
    - Sex
    - State(s) of Licensure and License Number(s)
    - Position/Specialty

2. The recruiter will request that the applicant send a written release by Fax or E-mail permitting MHM to request his/her NPDB report.

3. The recruiter will forward the information needed for the NPDB inquiry and the written release of information from the applicant to the MHM recruitment coordinator via E-mail. This E-mail will also indicate the Program Manager and contract for which the applicant is seeking employment.

4. The MHM recruitment coordinator will make an electronic request to obtain the NPDB report.

5. When the response to the NPDB inquiry is received and if the report indicates no sanctions, disciplinary actions, and/or other concerns or conditions, the MHM recruitment coordinator will E-mail the NPDB report to the recruiter and the Program Manager and will continue with New Hire Process. When an applicant accepts employment with MHM, the recruiter will forward the NPDB report to the credentialing agency. The Program Manager will use his/her copy of the NPDB report to initiate the employee's Credential File.

6. When the response to the NPDB inquiry is received with any indication of sanctions and/or disciplinary actions, the recruitment coordinator will E-mail the NPDB report to the Program Manager and the designated Clinical Operations staff member for review.

7. The designated Clinical Operations staff member will review the NPDB report for concerns or conditions that require consideration prior to offering the individual a position with MHM. This review will be completed within two working days of receipt of the NPDB report.

8. If the initial review by the designated Clinical Operations staff member does not identify significant concerns, the recruiter and Program Manager will be immediately notified. When an applicant accepts employment with MHM, the Program Manager will use his/her copy of the NPDB report to initiate the employee's Credential File.

9. If the initial review by the designated Clinical Operations staff member indicates that there is potential concern, the case will be referred to the MHM Credentialing Review Committee. The committee will complete its review and determine if the concern should preclude employment of the individual by MHM following the procedures outlined in the Committee's By-Laws.

10. Reviews by the MHM Credentialing Review Committee will be completed during a weekly conference call. All NPDB reports received at least 48 hours prior to the weekly call will be discussed.

11. Recommendations of the MHM Credentialing Committee will be sent by E-mail to the recruiter, Program Manager and Senior Vice President of Operations.

12. When the "offer letter" is sent to a potential employee, the applicant is advised to return the fully completed application, a release of information consent form and the credentialing documentation listed below. When the potential employee has accepted employment, the credentialing documentation will be sent to the Program Manager of the contract where clinical services are to be provided to initiate the Credential File:
    - Current License
    - Curriculum Vitae/Resume
    - Diplomas/Certificates verifying education; includes copy of diploma, and Educational Commission for Foreign Medical Graduates (ECFMG) certification for foreign graduates; post graduate training (internship, residency, preceptorships and post-doctoral fellowships)
    - Drug Enforcement Administration Certification (prescribers of medication)
    - Copies of other applicable certifications, such as advance practice certification for nurse practitioners.
    - Current CPR/AED Certification
    - Other certifications required by the client
    - Three references with indications from the recruiter that these references had been contacted and any information provided.

13. The release of information and questions required by the credentialing company needed to complete the credential verification process are included on the MHM application. Applicants are advised to complete the application questions in full and accurately since the verification process is based on this information. Successfully completing the credentialing verification process is required to maintain employment with MHM.

14. The credentialing company will review credentials through primary source verification. When completing verification by the internet or telephone, the credentialing specialist will provide documentation indicating the date of the verification, the source of the verification, the agency contacted and its phone number (if relevant), and the name of the agency representative who verified the information (if relevant). The credentialing specialist who completes the verification will sign and date the document.

15. The credentialing company will complete the credentialing process as soon as possible after the applicant's authorization for release of information is received. New staff who begin job duties before the credentialing process is completed will be advised that continuing employment with MHM requires successful completion of the credentialing process.

16. The collection of credentialing information takes time especially when inadequate information is provided by the prospective employee. The Program Manager will be informed when the credentialing agency completes the verification process or when the process is stalled more than three days due to missing information.

17. Documentation of the credentials and primary source verification process will be maintained in the staff member's Credential File.

18. After a physician, nurse practitioner, physician assistant, dentist or licensed doctoral level psychologist has been hired by MHM, the NPDB will be queried no less than annually for any disciplinary actions that may have occurred since the individual's employment. The query will be completed by the contracted credentialing agency. These inquiries will be completed each year during the month of the contract's anniversary date.

19. If the annual NPDB reports, completed and forwarded by the contracted credentialing agency, include sanctions or disciplinary actions during the last year, the report will be sent to the designated Clinical Operations staff member for review. In cases in which Clinical Operations staff member judges there may be a potential significant concern, legal and MHM management staff will be advised of the concern.

20. When locum tenens staff are used for temporary provision of psychiatric services, the company supplying the locum tenens staff will confirm that the credentials of staff are consistent with the relevant job description and the licensure and certification requirements of the jurisdiction. The company will supply credentialing documentation for locum tenens staff if required by the client.

<u>Credentialing Process for Licensed Masters Level Mental Health Professionals and Nurses</u>

1. It is essential that the Program Manager knows the specifics of the credentialing requirements of his/her contract for masters level mental health professionals and nurses.

2. When licensed mental health professionals and nurses are offered a position with MHM, they will be requested to provide a copy of their license. If the jurisdiction does not permit copying of licenses, the original license must be presented to the Program Manager or designee on the first day of hire. The Program Manager or designee will confirm in writing that the license was produced. This document will be placed in the Credential File.

3. Licensed mental health professionals and nurses will also be requested to provide documentation of completion of educational requirements and other certifications based on the mandates of the client.

4. Each potential employee will also provide evidence of current CPR/AED certification.

5. Regional Office staff who have received training in credentialing will contact the social work, counselor or nursing board to verify current licensure and to determine if sanctions or disciplinary actions are on the potential employee's record. If there is a record of sanctions or disciplinary actions, the Program Manager, in consultation with the Regional Vice President, will decide if the individual will be employed by MHM and, if employed, how compliance with recommendations of the licensing board will be ensured.

6. MHM staff are responsible for providing the Program Manager or designee documentation that required licenses and certifications have been renewed prior to their expiration. Staff who do not submit the documentation of license and certification renewals will be suspended without pay until the documentation is provided.

7. For current MHM staff, Regional Office staff who have received training in credentialing will contact the social work, counselor or nursing board annually to verify current licensure and to determine if sanctions or disciplinary actions may have occurred since the individual's employment. If sanctions or disciplinary actions are identified, the Program Manager, in consultation with the Regional Vice President, will decide if the individual will be permitted to continue employment with MHM and, if employment with MHM is to be permitted, how compliance with recommendations of the licensing board will be ensured.

8. Any variance in the credentialing process for Licensed Mental Health Professionals and Nurses requires the approval of the Senior Vice President of Operations.

<u>Credentialing Process for Non-Licensed Staff:</u>

1. When non-licensed staff, such as activities technicians, bachelor level clinicians and support staff, are offered a position with MHM, they will be requested to provide evidence of the completion of educational requirements included in the relevant job description. This document will be placed in the Credential File.

2. Each potential employee will provide evidence of current CPR/AED certification.

3. All non-licensed applicants will be informed that employment is contingent on proof of education and CPR/AED certification.

MHM Employee Files

1. The Program Manager is responsible to assign the preparation and maintenance of three files for all staff: the Personnel File, the Credential File, and the Health and Safety File.

2. Employee files are maintained in locked file cabinets within the Regional Office with access restricted to appropriate staff and/or agencies.

3. The Personnel File contains human resource information such as the employee application with release of information, letters of recommendation, signed job description, signed orientation check list, performance evaluations, salary information, and other human resource required documents.

4. Personnel Files are internal to MHM and are not shared with the client. Performance evaluations and salary information do not have to be shared.

5. The Credential File contains the documentation that supports the credentialing process and validates the qualifications of staff member to provide clinical services. The documentation includes the following information about licensed professional staff:
    - Primary source verification of highest level of education or board certification (includes copy of diploma, and ECFMG certification for foreign graduates) and post graduate training (internship, residency, preceptorships and post-doctoral fellowships)
    - Primary source verification of professional licensure relevant to employment position. Copy of professional licensure. License renewal copies must be confirmed with appropriate professional state licensing board.
    - Primary source verification of Drug Enforcement Administration certification for prescribers. Copy of DEA certification.
    - Query of the Office of Inspector General (OIG)
    - Query of the Government Services Agency (GSA)
    - Query of the National Practitioner Data Bank (NPDB)
    - Copies of other applicable certifications, such as advance practice certification for nurse practitioners
    - Copies of current CPR/AED certification
    - Record confirming annual TB testing and offering of Hepatitis B vaccination.
    - Signed job description. While the original of the job description is maintained in the Personnel File, maintaining a copy in the Credential File is recommended since job descriptions are reviewed during NCCHC and ACA audits.
    - Continuing education certificates have typically been maintained in the Credential File. NCCHC no longer requires documentation of completion of continuing education in those states in which licensing boards have mandated a minimum of 12 hours of continuing education. In states in which this minimum requirement has not been

established by state licensing boards, inclusion of continuing education certificates in the Credential File continues to be required. In addition, in some contracts, the client requires documentation of staff participation in on-site training and off-site continuing education. If required, maintaining this information in the Credential File is recommended.

6. Credential Files will be available for review by the client agency or other agencies authorized by the client. MHM may be required to periodically submit a roster of staff whose professional credentials have been certified to the client.

7. Each staff member has the right to review or receive a copy of any information in his/her Credential File, Personnel File and Health and Safety File.

8. The recommended organization of the Credential File to facilitate consistency and support reviews by the client, NCCHC, ACA and other authorized auditors follows:

Section One:
- Current License
- DEA Certificate (Physicians, Nurse Practitioners, Physician Assistants, and Dentists)
- National Practitioner Data Bank Queries, both initial and annual (Physicians, Nurse Practitioners, Physician Assistants, Dentists and Licensed Psychologists)
- Any OIG and GSA Inquiries
- Release of Information Consent Form
- Primary Source Verification

Section Two
- Curriculum Vitae/Resume
- Education
- Diplomas/Certificates

Section Three
- Other certifications required by the client

Section Four
- Signed Job Description
- CPR/AED Certification
- Confirmation of TB Testing annually and offering of Hepatitis B vaccination

Section Five
- Continuing Medical Education/Continuing Education Units (if applicable)
- Participation in site-specific inservice training (if applicable)
- Miscellaneous

9. The Health and Safety File contains the following health information for the employee: TB skin testing screening and results; Hepatitis B vaccination or declination; and other diagnostic testing or treatment arising from work requirements

or required due to a work-related injury such as a needle stick or a fall. Other information related to medical care and job absences (FMLA) should be sent to the Corporate Human Resources department.

10. It is recommended that employee Health and Safety Files be maintained in the Regional Office rather than at individual sites to ensure the confidentiality of the information.

11. To maintain the confidentiality of the sensitive information in an employee's Health and Safety Files, it is strongly recommended that an easily accessible database is developed to monitor the TB skin testing screenings and accepting/declining Hepatitis B vaccination to minimize the need to access an employee's Health and Safety File.

Maintaining Current Information in Credential and Health and Safety Files

1. The Program Manager is responsible for the development of a program-wide tracking system that permits the tracking of employee credentialing, training and health and safety requirements

2. The Program Manager or designee maintains a database of all staff indicating the status of licenses and certifications by expiration date, receipt of credentialing information, and the status of TB testing and Hepatitis B vaccinations. The database may also include a record of an employee's participation in in-services and/or continuing education.

3. The database will include the following information:
    - Staff member name
    - Position
    - Date of hire
    - Date when client's orientation/training
    - Date of licensure (as verified) and date license expires
    - Date of DEA certification (if relevant) and date DEA certification expires
    - Date of current CPR/AED certification expiration
    - Date diploma received
    - Date Curriculum Vitae/Resume received
    - Date job description signed
    - Date of most recent query regarding professional sanctions and/or disciplinary actions (NPDB or state licensing board)
    - Date of most recent TB skin test
    - Date of accepting/declining Hepatitis B vaccination
    - Dates/topic/credits earned for CME/CEU training (as required by the contract)
    - Dates/topic/trainer/hours of in-service training (as required by the contract)

4. The log should provide quick reference to alert staff when the license, DEA Certification or CPR/AED certification of a specific employee is going to expire. The log may be manual or maintained on an electronic spread sheet. A spread sheet is recommended to permit sorting the various elements by date so that staff can be alerted when evidence of re-licensure/re-certification is required.

5. When the licensure/certification database or periodic audits indicate that credentials need to be updated or there is missing information in the Credential File, the staff member is sent a letter requesting that the documentation is provided within a five working days. A copy of this letter will be placed in the Employee (or Credential?) File. Staff who do not submit the documentation of license and certification renewals will be suspended without pay until the documentation is provided.

MHM CREDENTIALING REVIEW COMMITTEE
Operational By-Laws

1. The MHM Credentialing Review Committee is responsible to review National Practitioner Data Bank (NPDB) reports as well as any further information obtained for physicians, nurse practitioners, physician assistants, dentists, and doctoral-level psychologists who are seeking employment with MHM when the NPDB report provides negative information that is of potential concern (hereinafter referred to as "Selected Reports").

2. The MHM Credentialing Review Committee is a three member panel composed of two physicians and a representative from Clinical Operations. An alternate physician and an alternate Clinical Operations representative participate in the committee's activities but only vote when necessary.

3. Members and alternates of the MHM Credentialing Review Committee sign a confidentiality agreement, prohibiting them from discussing any sensitive information outside of the venue of the Credentialing Review Committee meetings and agreeing to follow only objective findings when making determinations.

4. Membership on the MHM Credentialing Review Committee is time-limited to no more than six consecutive months. When one member's membership expires, he/she is replaced by another member. Members can serve more than one term on the Committee as long as the terms of service are not contiguous.

5. Operations of the MHM Credentialing Review Committee are facilitated by a designated Clinical Operations staff member who does not participate in the panel's decision making as either a member or an alternate. This facilitator sets the specifics parameters for each discussion, assigns the floor to members, calls for a vote of members, takes minutes and otherwise sets and enforces parliamentary procedure for the meetings. As described below, this designated Clinical Operations staff member functions as the initial screener in the NPDB review process.

6. The designated Clinical Operations staff member receives copies of all NPDB reports, as well as any further information obtained, of MHM applicants that indicate the presence of some negative information in the applicant's past. If this information raises concerns by the Clinical Operations staff member, the case is referred to the MHM Credentialing Review Committee.

7. If there are concerns regarding the information contained in the NPDB report, the designated Clinical Operations staff member will electronically scan the Selected Report and E-mail the report to the panel members and alternates within 48 hours of receipt. If clarifying information could be useful, legal support will be requested to provide additional information about the Selected Report. Determination of the need to obtain legal support will be in consultation with an administrative Clinical Operations staff member or designee.

8. A weekly conference call will be conducted for members and alternates of the MHM Credentialing Review Committee to review referred cases. Alternates may substitute for a member of the panel when the panel member is unable to participate in the conference call or if a conflict of interest exists. If a referred case involves an applicant for the contract of one of the two physicians on the panel, the alternate physician will assume that panel member's responsibility for the specific case.

9. Members of the MHM Credentialing Review Committee panel are encouraged and expected to make independent decisions regarding the potential suitability of an applicant for MHM employment. If a panel member has questions that cannot be answered by the available information, the case may be deferred to permit the information to be accessed.

10. After review of each case, the panel members will be asked to recommend whether or not the applicant should be hired by MHM.

    a. If three panel members recommend hiring, the credentialing review process is completed.

    b. If two panel members recommend hiring, the alternate physician makes his/her recommendation. If this recommendation is affirmative, the applicant is recommended for employment. If this recommendation is negative, the applicant is not recommended for employment.

    c. If only one panel member recommends hiring and two recommend against, the credentialing review process is considered completed and the applicant is not recommended for employment.

11. The designated Clinical Operations staff member is responsible to facilitate and coordinate the activities of the MHM Credentialing Review Committee. These duties include the following:

    a. Completing the initial review of NPDB reports that have negative findings and determining which reports require further review based on established criteria.

    b. In consultation with a Clinical Operations administrator, requesting information from legal support when the NPDB reports do not provide sufficient information for decision making.

    c. E-mailing Selected Reports requiring further review and other information to members and alternates of the MHM Credentialing Review Committee within 48 hours of receipt.

    d. Alerting MHM Credentialing Review Committee members of weekly conference calls and the cases to be discussed. Canceling the weekly conference call 24 hours in advance if there are no pending cases for review.

e. Facilitating weekly MHM Credentialing Review Committee conference calls by providing a brief synopsis of each case, assigning the floor to members, calling for a vote of members, taking minutes and otherwise setting and enforcing parliamentary procedure for the meetings.

f. Informing Program Manager and recruiter of decisions of MHM Credentialing Review Committee immediately after the conference call.

g. Maintaining a log of cases reviewed and the recommendations of the MHM Credentialing Review Committee.

h. Maintaining files of the NPDB reports reviewed.

12. The MHM Credentialing Review Committee will review the By-Laws governing its operations no less than annually and revise the procedures as needed.

NCCHC and ACA Standards Related to Credentialing

National Commission on Correctional Health Care (NCCHC) Standards (2008):

J-C-01/P-C-01 (essential): All health care personnel who provide services to inmates are appropriately credentialed according to the licensure, certification, and registration requirements of the jurisdiction.

Compliance Indicators

1. The responsible health authority (RHA) assures that new hires undergo a credentialing verification process that confirms current licensure, certification, or registration.
2. The credentialing process includes inquiry regarding sanctions and disciplinary actions of state boards, employers, and the National Practitioner Data Bank (NPDB).
3. Health care professionals do not perform tasks beyond those permitted by their credentials.
4. The RHA maintains verification of current credentials for all qualified health care professionals at a readily accessible location.
5. A license specifically restricting practice to correctional institutions is not in compliance with this standard.
6. All aspects of the standard are addressed by written policy and defined procedures.

Definition: Restricted licenses refers to licenses that have attached stipulations that must be followed. Different state licensing boards refer to these modified licenses by various names including temporary, probation, stipulated order or agreement, practice restriction, institutional, restricted, disciplinary, provisional, limited, and conditional.

Discussion: An intent of this standard is that the facility's qualified health care professionals are legally qualified. It is the responsibility of health professionals to maintain their license, certification, or registration. It is helpful for the facility RHA to keep copies of these documents on site. Procedures for verification of credentials of new hires should include the following: identification of the person responsible for conducting the verification; action that person should take in the confirmation process; agencies that should be called; inquires about sanctions or disciplinary actions that state boards, other employers, and the NPDB have taken; and procedures for periodic reconfirmation. Background checks for child and sexual abuse are required by law in some states. Also see P-C-02 Clinical Performance Enhancement.

Students in the various health professions may receive training in correctional environments to supplement services under the supervision of appropriate qualified health care professionals just as they would in a community setting. If used, students are properly oriented (see P-C-09 Orientation for Health Staff) and identified. They do not perform tasks beyond those permitted by their student status.

Most facilities employ health care professionals qualified to work in a community setting as well as in the institution. There are some circumstances in which facilities may employ health professionals with restricted or probationary licenses; however, they may not employ so many that supervision, patient advocacy, or independent medical practice is compromised. (See the NCCHC position paper on Licensed Health Care Providers in Correctional Institutions-attached). Except for federal employees, licenses and credentials for health professionals are from the state in which they practice.

National Commission on Correctional Health Care (NCCHC) Mental Health Standards (2008):

MH-C-01 (*essential)*: All mental health staff who provide services to inmates are appropriately credentialed according to the licensure, certification, and registration requirements of the jurisdiction.

Compliance Indicators

1. The responsible mental health authority assures that newly hired mental health staff undergo a credentialing verification process that confirms current licensure, certification, or registration.
2. Once hired, mental health staff are responsible for bringing to the attention of the responsible mental health authority any changes to their credentials.

3. The credentialing process includes inquiry regarding sanctions and disciplinary actions taken by state boards, former employers, and the National Practitioner Data Bank (NPDB).
4. Mental health staff do not perform tasks beyond those permitted by their credentials.
5. The responsible mental health authority maintains verification of current credentials for all qualified mental health professionals at a readily accessible location.
6. A license that restricts practice to correctional institutions is not in compliance with this standard.
7. All aspects of the standard are addressed by written policy and defined procedures.

Definition: Restricted licenses refers to licenses that have attached stipulations that must be followed. Different state licensing boards refer to these modified licenses by various names including temporary, probation, stipulated order or agreement, practice restriction, institutional, restricted, disciplinary, provisional, limited, and conditional.

Discussion: The intent of this standard is that mental health professionals are legally qualified to provide such services. It is the responsibility of health professionals to maintain their license, certification, or registration. It is helpful for the facility RHA to keep copies of these documents on site. Most facilities employ mental health professionals qualified to work in a community setting as well as in the institution. There are circumstances in which facilities may employ mental health professionals with restricted or probationary licenses; however, they may not employ so many that supervision, patient advocacy, or independent medical practice is compromised. (See the NCCHC position paper on Licensed Health Care Providers in Correctional Institutions-attached). A restriction to practice only in correctional settings is not acceptable.

Correctional institutions can be excellent sites for practicums and clinical rotations before licensure. Students in the mental health professions should be properly oriented and supervised during the rotation. Students should wear properly identification indicting their student status. They do not perform tasks beyond those permitted by their student status and training. Except for federal employees, licenses and credentials for mental health professionals are from the state in which they practice. For federal sites, license and credentials in at least one state are required for clinicians who require them.

Optional Recommendations: The verification or credentialing process for new hires should include the following: identification of the person responsible for conducting the verification; what actions that person should take in the confirmation process; which agencies should be called; inquires about sanctions or disciplinary actions that state boards, other employers, and the NPDB have taken; and procedures for periodic reconfirmation. Background checks for child and sexual abuse are required by law in some states.

American Correctional Association (ACA) Standards:

1-HC-2A-05 (Ref. 3-4334): *(MANDATORY)* All professional staff comply with applicable state and federal licensure, certification, or registration requirements. Verification of current credentials and job descriptions are on file in the facility.

Comment: None.
Protocols: Written policy and procedure. Copies of licensure requirements.
Process Indicators: Personnel records. Documentation of licensure, certification, or registration. Documentation of current credentials.

1-HC-2A-03: *(MANDATORY*) If the facility provides health care services, they are provided by qualified health care personnel whose duties and responsibilities are governed by written job descriptions that are on file in the facility and are approved by the health authority. If offenders are treated at the facility by health care personnel other than a licensed provider, the care is provided pursuant to written standing or direct orders by personnel authorized by law to give such orders.

Comment: Job descriptions should include qualifications and specific duties and responsibilities. Verification consists of copies of credentials or a letter confirming credential status from state licensing or certification body. Standing medical orders are for the definitive treatment of identified conditions and for the on-site emergency treatment of any person having such condition. Direct orders are those written specifically for the treatment of one person's particular condition.
Protocols: Written policy and procedures. Job descriptions. Standing orders.
Process Indicators: Verification of credentials or licensure. Documentation of compliance with standing orders. Health record entries. Interviews.

National Commission on Correctional Health Care: Position Paper
Licensed Health Care Providers in Correctional Institutions

Introduction

The National Commission on Correctional Health Care and the Society of Correctional Physicians are not-for-profit organizations that work toward the improvement of health services in the nation's jails, prisons, and juvenile detention and confinement facilities. The Society is an organization of physicians specializing in correctional medicine. The Commission publishes health services standards and operates a voluntary accreditation program for institutions that meet these standards.

Occasionally, an issue arises that has not been addressed by the Commission's standards or has changed since the standards were last revised. One such issue is state licensing boards' issuance of restricted licenses to medical professionals working in corrections. Accordingly, the Commission and the Society have adopted the following position statement that, along with the published standards, may assist facilities in designing their own procedures on this matter.

Background

State licensing boards are agencies charged with the responsibility of protecting the health and safety of the public by ensuring that health practitioners have attained the appropriate education and abide to ethical and professional standards of conduct. In addition, each state has a medical practice act that governs the issuance of licenses and the practice of medicine within its jurisdiction. When a physician violates these professional standards or the medical practice act, a state board is empowered to modify, suspend, or revoke that physician's license.

Some medical providers, whether working in the corrections environment or not, may develop diseases or exhibit behaviors that make it inappropriate for them to practice their profession without some sort of supervision. State licensing boards, therefore, occasionally modify a license for a physician or other provider in need of professional counseling and rehabilitation for drug, alcohol, or other impairments.

In addition, some state licensing boards, in an effort to accommodate selected recent émigré physicians, have granted special licenses to these physicians so that they may work in special institutional settings. These individuals do not meet the requirements of a fully licensed physician.

Different state boards will refer to these modified licenses by different names, including temporary, probation, stipulated order or agreement, practice restriction, institutional, restricted, disciplinary, provisional, limited, and conditional. This position statement will use the term "restricted" throughout.

The practice of medicine in a correctional setting is a discipline that requires knowledge of medicine as well as law and criminal justice. Working in a correctional facility provides an excellent opportunity for motivated physicians to encounter a variety of medical conditions and illnesses, treat patients, and have a major impact on public health.

One of the challenges faced by physicians and other health practitioners in corrections is providing necessary patient care within a rigorous security environment and in concert with security personnel. Another challenge is providing constitutionally required care within a limited budget. Yet another challenge is to keep resources in pace with the growing number of persons incarcerated. The best physicians will be particularly adept at providing and advocating good patient care within an environment that at times may seem to provide disincentives to patients and practitioners alike.

When correctional physicians do not advocate appropriate medical care for their patients, they risk harm to their patients; their employer, in the form of lawsuits or public outcry; the public, in the form of health threats or increased cost for patient care upon release; and the medical profession and its canon of ethics.

Correctional systems, perhaps in an attempt to save money or adhere to a security procedure that has not been adapted for medical care, may create pressures to modify or avoid necessary patient treatment. Restricted licensed physicians, perhaps due to their inability to easily find employment elsewhere, may be susceptible to pressures or excessive supervision placed on their medical autonomy. To be an effective patient advocate, a physician must be able to resist pressures and constraints on his/her independent medical practice.

State medical and dental boards must report to the National Practitioner Data Bank (NPDB) disciplinary actions related to professional competence or conduct taken against the licenses of physicians, providers, or dentists. State medical and dental boards also must report revisions to adverse licensure actions. Correctional employers should check a prospective physician's credentials by contacting the NPDB and state regulatory agencies.

Position Statement

The National Commission on Correctional Health Care and the Society of Correctional Physicians advocate that physicians, nurses, and other licensed health care providers working in corrections be fully licensed. Corrections departments should employ only health care providers who may freely work in a community setting as well as in a jail, prison, or juvenile confinement facility.

The Commission and the Society believe that licensed health care providers who suffer from a disease or behavior disorder should be able to participate in a properly supervised rehabilitation program, whether in a community setting or the corrections environment. An employer should not employ so many restricted or probationary licensed health care providers that it interferes with supervision, patient advocacy, and independent medical practice.

State licensing boards should not issue licenses that restrict licensed health care providers' employment solely to correctional environments. The Commission and the Society believe that such practice imparts a sense that patients in a correctional environment are undeserving of qualified care, similar to what is available in the community. This concept is anathema to the important medical canons of ethics and disregards the important public health role correctional health care can play.

Further, correctional systems should not employ licensed health care providers whose licenses are so restricted. It conveys a substandard image of correctional health care that can inhibit patients from seeking necessary care; adversely affects recruitment of other health professionals; and potentially leads to unwelcome public reaction when there is a negative patient outcome. The public specter of inadequacy in the correctional medical system may erode the system's ability to attain the resources necessary to operate the system effectively.

It is important to note that this issue transcends physician qualification. It also applies to nurses, physician assistants, psychologists, and dentists. These practitioners should be held to the community standard for competent health care whether they provide services to prisoners or the non-incarcerated population. It is inappropriate to build a correctional health care system on health care practitioners who have licenses limited to corrections only.

Adopted by the National Commission on Correctional Health Care Board of Directors: November 7, 1999

Robert Michael Hooper, Ph.D.
Regional Director

Profile:

- 36 years of experience in correctional mental health services.
- Leading expert in the field of substance dependence and abuse within a correctional health setting. Instrumental in the development and implementation of such programs in the states of California, Delaware, Maine, New Jersey, South Carolina, and Texas.
- Responsible for developing and supervising intensive treatment programs in prisons and jails nationwide.
- An expert in the field of crisis intervention for depressed and violent inmates.
- Experience coordinating the staff and services of psychiatric and psychology staff as well as medical, dental and mental health staff.

Education:

PhD, Social Psychology, New York University
MA, Social Psychology, New York University
MSW, Case and Group Work, Portland State University
BA, Sociology, California State University, Hayward

Current Positions:

January 2009 – Present
MHM-Services Maryland
Program Manager

Responsible for the oversight of all mental health services provided for the Maryland Department of Public Safety and Correctional Services. Oversees intake screening services and ensures seven day follow-ups for all new commitments to Pre-Trial Services. Ensures MHM work meets DOJ requirements within the Pre-Trial Services facilities (DOJ review in December of 2009 resulted in positive feedback concerning mental health services). Provides supervision for the two inpatient mental health units, one at the Baltimore City Detention Center and one at Correctional Mental Health Center- Jessup.

2003 - Present
Strategic Solutions for Public Safety
CEO

Work with criminal justice professionals to determine how to provide the best treatment experience for offenders using existing resources. Provide training for treatment and correctional staff.

Previous Experience:

2002 – 2003
Civigenics,
Vice President of Clinical Affairs

Oversaw treatment programs nationally, and developed and revised and updated treatment curricula.

2000-2002
Correctional Medical Services
Executive Director of Substance Abuse Treatment and Regional Vice President

Supervised the provision of intensive drug treatment programs and the healthcare services provided for the Delaware Department of Corrections.

1994 – 2000
Correctional Medical Services
Executive Director of Substance Abuse

Responsible for oversight and development of intensive treatment programs in prisons and jails nationwide.

1990 – 1994
Correctional Medical Services
Regional Vice President

Delivered healthcare and mental healthcare for the states of Delaware, Maryland, Pennsylvania, and West Virginia.

1989– 1990
Correctional Medical Services
Regional Manager

Oversight of health and mental healthcare for the states of Delaware, Maryland, Pennsylvania, and West Virginia.

1985-1989
Correctional Medical Services
Administrative Director

Administered comprehensive health and mental health contract for the Delaware Department of Correction. Provided medical, dental, psychiatric, and mental health services.

1985-1985
Correctional Medical Services
Director of Mental Health Services

Coordinated the services of the psychology and psychiatric staff. Hired, trained, and supervised staff, as well as direct clinical work with inmates.

1982-1985
Frank E. Basil, Inc
Director of Mental Health Services

Responsible for coordinating the services of the psychology and psychiatric staff. Hired, trained, and supervised staff, as well as direct clinical work with inmates.

1978-1982
Prison Health Services
Social Psychologist

Provided crisis intervention with depressed and violent inmates. Conducted group counseling and evaluation of inmates for classification and release, as well as evaluations for parole candidates.

1977-1978
Program of Human Relations and Social Policy
Admissions Coordinator

Processed applications, answered questions from applicants, and interviewed applicants for the program.

1977-1978
Program of Human Relations and Social Policy
Teaching Fellow

Consulted with first year students concerning academic issues and adaptation to graduate school.

1977-1978
Delaware Council on Crime and Justice
Consultant

Provided crisis intervention to depressed and violent inmates. Also conducted group counseling. Designed and implemented a training sequence for the League of Women Voters, Delaware, for a court observation program. Other consultant work included developing training sequences for high school students concerning the criminal justice system and doing research work on mandatory sentencing.

1977-1977
Center for the Study of Human Relations
Chief Assessor

Responsible for coordination of on-going assessment project carried out by the Center for the Study of Human Relations. Assignments included development and implementation of assessor training, as well as coordination of logistics.

1976-1977
Administrative Office of the Courts, State of Delaware
Evaluator for Misdemeanant Processing Project

Worked as a consultant to analyze the effectiveness of six different components that make up the Misdemeanant Processing Project. This project included doing extensive work with various police agencies, as well as the Attorney General's office.

1975-1976
Bridge House, Detention Center for Juvenile Delinquents, State of Delaware

Worked part-time supervising adolescents in a group setting, as well as doing intake work.

1972-1974
Children's Services Division, Lane County Oregon
Group Worker

Developed group counseling sessions for parents who had their children removed due to abuse and/or neglect. The job also included individual and family counseling, as well as training staff members.

1971-1972
Villa Saint Rose
Group Worker

Responsibilities included supervising a group of girls, as well as participating in the development and implementation of treatment strategies for girls.

1970-1972
Multnomah Juvenile Department
Probation Officer

Worked with runaway adolescents, as well as adolescents with drug problems. The work also included family counseling.

1970-1972
The Farm House
Caseworker

Responsibilities included developing and implementing treatment strategies for boys in one of the living units.

1969-1970
California Youth Authority
Undergraduate Field Placement

Undergraduate field placement with the California Youth Authority, Oakland. This placement included working in a number of institutions, as well as working with parolees.

1969-1981
Bearskin Meadow Camp
Coordinator of Counselors

Provided a counselor-in-training program for adolescents at a co-educational diabetic youth camp. The emphasis of the training was to teach adolescents how to work with children especially to teach diabetic children how to manage their diabetes.

Academic Appointments:

1974
Visiting Instructor, Lane Community College, Eugene, OR

Speeches/Publications:

2004

- Panel member of Mayor Richard Daily Jr.'s Mayoral Policy Caucus on Prison Reentry. Focus of presentation was on the importance of providing a continuum of care for inmates with drug and alcohol problems.

- "Needs and Outcomes for Serious Juveniles Incarcerated in An Adult Correctional Institution," with Christine A. Saum, Alison R Gray, Martha Boston and Jill Walters, paper presented at the American Criminal Justice Society Annual Conference.

2003
"Something Works: Therapeutic Communities in the Treatment of Substance Abuse," in Correctional Psychology Practice, Programming, and Administration Barbara Schwartz, ed., Civic Research Inst., Kingston, N. J.

1998

"Examining Substance Abuse Treatment for the Incarcerated" presented at the Managed Behavioral Health Care in the Criminal Justice System, Atlanta, Georgia.

1997

- "Intensive Substance Abuse Treatment in a Correctional Setting" presented at the National Leadership Council for The Institute for Behavioral Healthcare.
- "Prison Therapeutic Communities for Substance Abusers Prove Successful," in Offender Programs Report, July/August 1997.
- "An Effective Model of Prison-Based Treatment For Drug-Involved Offenders," in Journal of Drug IssuesWith James A. Inciardi, Steven S. Martin, Clifford A. Butzin, Lana D. Harrison.
- "The Therapeutic Community Continuum in Corrections,"in Community As Method: Therapeutic Communities for Special Populations and Special Settings with with D. Lockwood, J. A. Inciardi, and C.A. Butzin, ed by G. DeLeon, Prager: Westport, Connecticut, 87 – 96.

1995

"Making Therapeutic Communities Work In Prison," presentation at the American Correctional Association Summer Conference. Published in the 1995 State of Corrections.

1994

"Substance Abuse: Through Therapy; Delaware Treatment Program Presents Promising Results," with Dorothy Lockwood and James A. Inciardi in Corrections Today, February 1994, Vol. 56, No. 1. (1996).

1993

- "Treatment Techniques in Corrections-Based Communities," with Dorothy Lockwood and James A. Inciardi in The Prison Journal, September-December 1993, Vol. 73, No. 3 & 4.
- "The Effectiveness of the KEY-CREST Continuum of Treatment," with James A. Inciardi and Dorothy Lockwood. Paper presented at The National Institute on Drug Abuse Second Annual Conference on Drug Abuse Research and Practice with James A. Inciardi and Dorothy Lockwood.

1991

- "Theory and Application, Applied to the Treatment of Substance Abusers," presented at American Correctional Health Services Association 16th Annual Multi-Disciplinary Training Session.

- "The KEY Program: Drug Treatment Within a Correctional Facility," with Bruce Wald in American Jails, September/October 1991, 50-54.

1990

"Obstacles to the Implementation and Evaluation of Drug Treatment Programs in Correctional Settings: Reviewing the Delaware KEY Experience," National Institute on Drug Abuse, Technical Review on Drug Abuse Treatment in Prisons and Jails in Rockville, Maryland, with James A. Inciardi, Steven S. Martin, Dorothy Lockwood, Bruce Wald.

Monitor on panel "Suicide in Prison and Jails," American Correctional Health Services Association 15th Annual Multi-Disciplinary Training Session San Francisco, California.

1989

"Do's and Don'ts When Implementing Intensive Treatment Programs." Presented at the Second Annual Prison/Jail Overcrowding Symposium, Orlando, Florida.

1988

"The Development of Corrections Based Therapeutic Community Substance Abusers: Concepts and Application" with Robert M. Merritt, Bruce Wald, and Debbi Boulden. Presented at the Fifth Annual Correctional Symposium: Casework and Mental Health.

1979

Social Assessment: A Manual for Neuropsychodiagnosis - Part I , unpublished manuscript with Frank B. W. Hawkinshire.

1977

Presented paper on "Psychological Impact of Juvenile Diabetes on Adolescents," to members of the International Diabetes Association during their fourth international conference. The paper is published in the proceedings of the conference.

Specialized Training:

2001

Consultant to Virgin Islands for implementing drug treatment services in their criminal justice system.

1999

Consultant to Argentine government for implementing drug treatment services in the Province of Salta.

1995

National Symposium on Substance Abuse Treatment in Corrections, “The Therapeutic Concept Implementation of a Therapeutic Community in a Correctional Setting.”

1986
Participant in three day workshop on Financial Management for the Non-Financial Manager at Wharton School of Business, Philadelphia, PA.

1984
Participant in three day workshop at Johns Hopkins University on Evaluation and Treatment of Sexual Offenders.

Honors:

1991
President's Award, Correctional Medical Systems

1988
Administrator of the Year, Correctional Medical Systems

1977-1978
Felix Warburg Scholar – New York University

1970-1975
Evelyn Guinaw Memorial Award for Scholarship (Diabetic Youth Foundation)

1970
Scholarship, Portland State University

Rock W. Welch, MS
Senior Vice President of Operations

Education:

MS, Augusta College
BS, Northern Arizona University

Current Position:

2006-Present
MHM Services, Inc.
Senior Vice President of Operations

Direct program operations to ensure full contractual compliance and meet client requirements. Develop budgets for mental health and medical contracts, including program development and implementation. Oversee regional directors and support contracts by allocating corporate support for operational activities. Conduct contract negotiations with client agencies to ensure full accountability for contract performance.

Previous Experience:

2003-2006
MHM Services, Inc.
Regional Vice President, Regional Director

Oversaw operations for contracts in Maryland, Ohio, Pennsylvania, and Vermont and for the Philadelphia Prison System. Deployed resources to support mental health programs.

2002-2003
C&L Bradford & Associates
Senior Associate

Oversaw implementation of settlement agreement between the Nassau University Medical Center and the Department of Justice for the Nassau County Correctional Center. Resulted in accreditation by two accrediting bodies.

1998-2001
Correctional Medical Services
Regional Vice President

Directed operations for a regional health care program with 14 major facilities, many small sites, and more than 900 employees. Obtained first-time NCCHC accreditation for 14 sites. Negotiated a three-year contract extension worth $90 million in annual revenue.

1997-1998
MHM Services, Inc.
Regional Director

Managed operations for the Georgia Department of Corrections contract.

1993-1997
Correctional Medical Services
Regional Administrator

Oversaw health care services for more than 4,000 inmates in facilities in central New Jersey.

1993-1996
Correctional Medical Services
Health Care Administrator

Managed health care units in correctional facilities.

1985-1993
Georgia Department of Corrections
MH/MR Unit Director, MH/MR Senior Counselor

MHM CLINICAL GUIDELINES
PSYCHOLOGICAL SERVICES

Mental Health Assessment of Ability to Make Informed Medical Decisions

The following Guidelines are intended to assist MHM psychiatrists and licensed psychologists who are responsible for completing mental health assessments of inmates' ability to make informed medical decisions and non-medical decisions with potential health consequences.

NCCHC standards require informed consent processes, including the assessment of an inmate's ability to make informed medical decisions, to follow the laws and regulations that are applicable in the jurisdiction in which the assessment is taking place. The ability to make informed medical decisions is inherent in the informed consent process. When an inmate's informed consent is required under NCCHC standards or other ethical standards (e.g., for invasive examinations and procedures, psychiatric or medical treatment, psychotropic medications or dental extractions) but the inmate, in the opinion of the mental health clinician, does not appear to be making decisions in his or her best interest, completion of an assessment of the inmate's medical decision-making abilities should be considered. Informed consent is dependent on the process that is used in reaching a decision; a reasonable decision alone is not necessarily indicative of competence or adequate medical consent.

This type of assessment is crucial when inmates persistently refuse nutrition (engage in a hunger strike) or essential medical care. In correctional settings, hunger strikes that result in potentially life-threatening medical conditions or other clinical indications are the most common situation in which medical decision-making abilities may need to be assessed.

In addition, in some jurisdictions, the lack of medical decision-making abilities is one of the requirements for the administration of non-emergency involuntary psychotropic medications. NCCHC standards also require evidence that an inmate is capable of making an informed and voluntary decision when executing living wills, advance directives and do not resuscitate (DNR) directives.

In civil and community settings, the determination of an individual's capacity to make informed medical decisions is a legal ruling made in Court. In correctional settings, mental health staff are expected to provide specialized consultation to medical and administrative staff regarding an inmate's ability to make informed medical decisions. These assessments are not intended to generate lengthy, comprehensive forensic reports, unless staff are qualified to conduct such evaluations, and they are a formal component of contracted services. These Guidelines should be used to assist in the development of findings and practical recommendations when mental health staff are required to provide such consultation.

Inmates need not be on the mental health caseload to require an assessment of their medical decision-making abilities. Conversely, provision of such assessment does not result in automatic placement on the caseload. If, however, mental illness is detected during the course of this assessment, placement of the inmate on the mental health caseload may be warranted.

MHM staff completing these assessments should be psychiatrists or independently licensed, doctoral level psychologists. These staff should have training in conducting assessment of medical decision-making capacity and experience in providing correctional mental health services. When possible, psychiatrists or psychologists who are already involved in the treatment of those inmates on the mental health caseload should complete these assessments due to their greater knowledge of the inmate's treatment needs and history.

Referrals for these assessments should be considered urgent. These assessments should be completed within one business day of receipt of the referral.

ASSESSMENT OF MEDICAL DECISION-MAKING ABILITY
CLINICAL GUIDELINES – PSYCHOLOGICAL SERVICES

This document was created to serve as a guideline for completion of mental health assessments of inmates' ability to make informed medical decisions. MHM psychiatrists and licensed psychologists complete these assessments when this task falls within the scope of MHM's contract, their training and job descriptions. If these guidelines conflict with local policy or expectations, please check with your clinical supervisor or Medical Director and use clinical judgment in resolving.

DEFINITION

A mental health assessment of an inmate's ability to make an informed medical decision is a specialized evaluation that assesses the inmate's decision-making process in light of the inmate's medical and mental health condition and the nature of the decision under question. In correctional settings, these assessments most often need to be made when an inmate engages in behavior with adverse health consequences, such as persistent refusal of nutrition (hunger strikes), or appears, in the opinion of the clinician, to be making important medical decisions that are contrary to his/her best interests. Assessment of medical decision-making abilities may also be necessary when inmates are engaged in making end-of-life decisions. The primary goals of these assessments are to: 1) support the inmate's autonomy and right to refuse treatment and temporarily refuse food; 2) support the inmate's health and well-being; and 3) provide recommendations regarding treatment.

LIMITS OF SCOPE AND INTENT

Assessment of inmates' ability to make medical decisions is conducted with respect to the specific medical decisions under consideration. A finding that an inmate lacks the ability to make an informed medical decision regarding one type of treatment does not mean that the inmate lacks the ability to make informed medical decisions regarding other types of treatment. Decision-making skills vary with the complexity of the information needed to make an informed medical decision and with the risk or likelihood of an adverse health outcome. An inmate's decision-making ability may also vary over time and can be restored in many cases. These assessments therefore may need to be repeated when, in the opinion of the clinician, clinical status changes. The intent of these Guidelines is not to generate lengthy forensic evaluations, but rather to support staff in conducting assessments. Regardless of whether the inmate is found to possess or lack the necessary medical decision-making abilities, this finding is only one element that should be taken into consideration when determining the inmate's course of treatment and management.

Determination that an inmate lacks capacity is ultimately a legal decision, and may require a specific procedure or hearing to be conducted, according to state and/or facility regulations. MHM staff should not participate in coercive or forced treatment, including nutrition, unless done in accordance with legal requirements for such intervention.

PROCEDURE

Recommendations: These assessments should be completed by a psychiatrist or independently licensed doctoral level psychologist. These staff should be trained in completing these assessments and experienced in providing correctional mental health care. As is always the case, these assessments should be completed in an objective, balanced and nonjudgmental manner. Referrals for these assessments should be considered urgent and the assessment should be completed within one working day of receipt of referral.

I. **Determination that an Assessment is Needed.** The need for an assessment of the inmate's medical decision-making abilities should be assumed if a referral for mental health assessment is received from facility administration or medical staff for an inmate who is hunger striking, or refusing medical examination and/or treatment that have been deemed essential to the inmate's well-being by the medical provider. Referral from mental health staff who have been involved in ongoing monitoring of the inmate's care may also prompt the need for assessment of the inmate's medical decision-making abilities. Such assessments may also be warranted for inmates who have developmental disabilities, cognitive impairments, dementia, communication barriers that appear to limit their ability to express a choice, or who are engaged in end-of-life decision-making.

II. **Sources of Information.** Staff should utilize all available sources in gathering data needed in their discretion for the assessment, including reviewing the record, interviewing the inmate and consulting with the referring staff. Sources of data should be sufficient to determine the inmate's mental status, diagnoses, behavior and thought processes, and the nature of the proposed treatment or nutrition. Consultation with medical staff prior to interviewing the inmate is recommended when the situation involves refusal of medical treatment, including clarification of the risks, benefits, and any alternatives to the proposed treatment.

III. **Medical Decision-Making Assessment**. These assessments require consideration of multiple areas of the inmate's decision-making process, including

- The inmate's diagnoses of medical and/or mental illnesses
- The inmate's mental status
- The key elements of the proposed treatment
- The inmate's decision-making abilities, including:
  - Ability to understand the information that is being disclosed about his/her own condition and the proposed treatment
  - Ability to appreciate the relevance of this information for the inmate's own circumstances
  - Ability to reason with the information, including ability to weigh options, balance risks and benefits, consider alternative treatments, and anticipate consequences
  - Ability to express a choice with regard to the proposed treatment

A finding of mental illness or intellectual impairment may be likely during the course of this assessment, since inmates who are referred for these assessments are usually exhibiting irrational or self-destructive behavior. Abnormal mental status may be the result of medical rather than psychiatric illness. While the presence of an abnormal mental status and/or mental illness may be likely, these conditions are often not sufficient for a finding that the inmate lacks capacity. Also, inmates with intact decision making capacities may volitionally engage in irrational or self-destructive behavior for other non-medical reasons, such as to be disruptive or be transferred to another facility.

A determination that the inmate lacks the ability to make informed medical decisions depends on a finding of clinically significant impairment in one or more of the four decision-making abilities listed above. Assessment of all four of these areas requires specific evaluation of the inmate's knowledge regarding the presence and nature of his/her condition or illness; nature of proposed treatment/intervention(s); and the risks, benefits, alternatives and consequences of each treatment and no treatment. Education of the inmate regarding diagnosis and treatment is fully appropriate during the course of the assessment. Such education may result in resolution of the underlying concerns that led to the original referral. Consider asking the inmate to repeat his/her understanding of relevant information in his/her own words to ensure comprehension. Consider asking the inmate to "reason out loud" or explain the reasoning for his/her decision.

In the majority of cases, a face-to-face interview with the inmate is required to evaluate decision-making abilities; record review alone may be insufficient except, by example only, in extreme cases of mental or physical deterioration. An interview should be attempted, and, if refused, the inmate should be informed of the reason it is being attempted. Evidence both for and against impairments in the four areas of medical decision-making should be considered. Conflicting, contradictory and missing data should be identified. Impairment in any one of the four decision-making abilities can render the inmate incapacitated depending upon the clinician's specific findings. For example, when the inmate lacks insight that he/she suffers from the condition that is the target for treatment, the inmate likely lacks the ability to make informed medical decisions with respect to that condition. When decision-making impairments are identified, they should be specified in the resulting assessment documentation.

IV. **Documentation.** Assessments of the inmate's medical decision-making abilities will vary depending upon the specific circumstance but generally should include a narrative description of the proposed medical intervention(s), the inmate's mental status, behavior and diagnoses, and the inmate's four decision-making abilities as they relate to the specific medical interventions under consideration. Explicit documentation of the rationale for reaching conclusions should be included. If there is reason to believe that the inmate's ability to make informed medical decisions can be restored, this should be stated, along with recommendations to support such restoration. These Assessments may be documented in progress notes, but using the attached template will assist in creating a comprehensive report. If the template is used, it should be filed in the inmate's medical record along with a brief progress note that documents the completion and outcome of the assessment.

MENTAL HEALTH ASSESSMENT OF INMATE'S ABILITY TO MAKE INFORMED MEDICAL DECISIONS

Inmate Name:		Inmate Number:
Date of Referral:	**Date of Assessment:**	**Institution:**

Nature of Proposed Medical Intervention or Inmate Behavior Requiring Assessment: *(provide brief narrative description)*

Inmate's Explanation of Refusal of Treatment or Nutrition: *(provide direct quotes whenever possible)*

Mental Status Examination

Conduct brief mental status examination

☐ Disorientated/Confused ☐ Non-responsive/mute ☐ Anxiety/Panic	☐ Disorganized thinking ☐ Delusional ☐ Hallucinations	☐ Elevated/Expansive ☐ Pressured Speech ☐ Hyper-religiosity	☐ Depressed Mood ☐ Suicidal ideation ☐ _____

Other:

Diagnostic Impressions

List current diagnostic impressions. If different from chart diagnoses, explain.

Assessment

Assess each of the four aspects of medical decision-making

Understanding	Inmate understands the information being disclosed about his/her own condition and the proposed treatment	☐ Yes	☐ No
Appreciating	Inmate is able to appreciate the relevance that this information has for his/her own circumstances (has insight)	☐ Yes	☐ No
Reasoning	Inmate is able to reason with the information, weigh options, balance risks and benefits, consider alternative treatments and anticipate consequences	☐ Yes	☐ No
Expressing	Inmate is able to express a choice with regard to the proposed medical intervention	☐ Yes	☐ No

Conclusion

State opinion as to inmate's medical decision-making abilities and provide rationale.

Treatment Recommendations:

Staff Signature:	Staff Name (Printed):
Title:	Date:

INDEX TO GENERAL GROUP CURRICULUM MODULES (Effective May 2009)

TITLE/OBJECTIVE OF GROUP	STRUCTURE/FORMAT OF GROUPS	COMMENTS
PSYCHOTROPIC MEDICATION EDUCATION GROUP: To provide general education regarding psychotropic medications currently prescribed group participants. Provide forum for inmate/detainee to discuss medication effects, side effects, expectations, successes and failures To offer constructive reinforcement for compliance with recommended psychotropic medication To ensure inmates/detainees understand the effects of heat and direct sunlight for individuals taking psychotropic medications	Module 1: Psychotropic Medications Module 2: Specific Types of Psychotropic Medication Module 3: Assuming Responsibility for Mental Illness Module 4: Psychotropic Medication and Heat	
SLEEP HYGIENE GROUP: To provide general education about sleep and the sleep problems often experienced when one is incarcerated. To provide inmates "sleep promoting" interventions other than medication. Provide forum for inmates to discuss their efforts to address sleep problems without medication. To offer reinforcement for efforts to use "sleep promoting" interventions other than medication. To provide opportunity to identify inmates for whom non-medication "sleep promoting" interventions are not effective and who may require medical review.	Module 1: Introduction to Sleep Hygiene Module 2: Tips for Improved Sleep Module 3: Benefits of Breathing and Exercise for Sleep Module 4: Relaxation Exercises	
COGNITIVE BEHAVIORAL THERAPY GROUP: Developed by: Jeffrey A. Wilson-Reese, Psy.D. Designed to help inmates utilize individual coping strengths and to aid in the development of new skills which may be used to achieve a more adaptive level of coping within a prison environment. Ten separate coping techniques are reviewed over the course of ten group sessions, with each technique being presented independent of others so that an inmate may reasonably begin the group during any of group sessions.	Module 1: Four-Step Deep Breathing Method Module 2: Progressive Muscle Relaxation Module 3: Identifying Personal Stressors Module 4: Visualization Module 5: Meditation Module 6: Humor Module 7: Cognitive Distortions Module 8: Cognitive Restructuring Module 9: Assertiveness Training Module 10: Anger Management	Overview of Cognitive Behavioral Therapy Group process is provided. Overview includes general information, proposed group structure, group rules and instructions regarding group operations. Following information is provided for each module (group session topic): Introduction; Lecture; Group Handout (when applicable); Group Activity; Summary of Group; and Inmate Reading All modules may be adopted to conduct a comprehensive group or individual modules may be selected for implementation. Videos referenced in curriculum (Shawshank Redemption and Cage the Rage) available and may be borrowed from the MHM Clinical Operations Resource Library. Inmate Readings provided for each module may be offered as in-cell treatment for inmates unable to participate in group programming due to security concerns or placement on segregation units.

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TITLE/OBJECTIVE OF GROUP	STRUCTURE/FORMAT OF GROUPS	COMMENTS
CAGE YOUR RAGE: ACA program to address anger management	Four video program available from Clinical Operations Resource Library	Program includes 4 videos, leader's guide and one copy of An Inmate's Guide to Anger Control workbook. Workbook can be used by leader to develop group sessions; however, only the anger log and relaxation log can be copied. For intensive anger management groups, workbooks can be ordered from ACA ($15 for each workbook). Video 1: Cage Your Rage: Anger – Past and Present (14 min): focuses on impact of childhood experience with violence and role of substance abuse in anger Video 2: Cage Your Rage: Anger – Anger and Aggression (22 min): addresses physical signs of anger and impact of feeling helpless on anger Video 3: Cage Your Rage: Anger – What Causes Anger (18 min): addresses role of self-talk in development of anger Video 4: Cage Your Rage: Anger – How to Manage Your Anger (20 min): addresses interventions for anger: steering clear; time out; self talk; and talk it out
DEPRESSION GROUP: To provide general education regarding different types of depression To identify symptoms and potential causes of depression To provide forum for group members to discuss their experience of depression To identify the thinking styles and stress factors that contribute to depression To introduce skills that may assist in reducing depressive feelings To provide reinforcement for group members using depression-reducing skills	Module 1: What is Depression? Module 2: Am I Depressed? Module 3: Understanding My Depression Module 4: Thinking Related to Depression Module 5: Stress Related to Depression Module 6: Taking Care of Myself Completion of a module will likely require more than one group session depending upon the time allotted for the group and the level of group interaction. Since sharing thoughts and feelings about depression is a major goal for the Depression Group, interaction should be encouraged. The group should have no more than 8 participants to facilitate open communication and interaction.	Initially developed for implementation with female inmates but useful for male inmates with minor revisions

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TITLE/OBJECTIVE OF GROUP	STRUCTURE/FORMAT OF GROUPS	COMMENTS
TRAUMA GROUP: To provide general education about trauma To provide information about types of trauma To identify symptoms and reactions to trauma To provide information about the recovery process To introduce idea of personal plan for recovery To initiate personal plan for recovery To provide forum for group members to discuss their experience of trauma	Module 1: What is Trauma? Module 2: Symptoms of Unresolved Trauma Module 3: Preparing for Recovery Module 4: My Thoughts and Feelings Module 5: Taking Care of Myself Completion of a module will likely require more than one group session depending upon the time allotted for the group and the level of group interaction. Since sharing thoughts and feelings about trauma is a major goal for the group, interaction should be encouraged. Group should have no more than 8 participants to facilitate open interaction.	Initially developed for implementation with female inmates but useful for male inmates with minor revisions.
TAKING A CHANCE ON CHANGE	In-cell psychoeducational programming for inmates in segregation units that includes 50 modules in 8 units Unit A: Preparing for Change Unit B: Self-Awareness/Goal Setting Unit C: Identifying and Changing Mistaken Beliefs Unit D: Effective Problem-Solving Unit E: Effective Communication Unit F: Anger Management Unit G: Stress Management Unit H: Relapse Prevention Each unit has 5 to 7 modules and a review assessment session at the end of the unit. Each module contains a handout and worksheet to be completed by the inmate Program documented in separate Clinical Operations Manual.	Program has proven effective for providing programming for inmates unable to participate in groups due to security concerns and segregation placement. Initially developed for implementation with female inmates but useful for male inmates with minor revisions

INDEX TO GENERAL GROUP CURRICULUM MODULES (Effective May 2009)

TITLE/OBJECTIVE OF GROUP	STRUCTURE/FORMAT OF GROUPS	COMMENTS
ANGER MANAGEMENT (High Functioning Inmates) By conclusion of group, participants will have learned to: • Engage in three types of relaxation skills • Understand the adaptive role of anger in their lives, including its benefits and potential risks • Identify triggering events and situations that typically prompt anger • Identify automatic thoughts, attitudes and "self-talk" that contribute to anger • Search for and identify "primary" emotions – such as embarrassment, humiliation, fear, and loss – that precede and contribute to anger • Self-monitor their anger and their coping techniques • Identify their dominant anger expression style • Understand the consequences of anger in their lives • Learn 12 anger management techniques • Develop their own long-term anger management plan to avoid aggressive and violent behavior	Fourteen group modules, each designed for one hour sessions with handouts and homework assignments. Module 1: Introduction and Self-Assessment Module 2: Learning to Rest Your Mind Module 3: Using Muscles and Imagination to Relax Module 4: Anger is an Emotion Module 5: Anger: The Good, the Bad and the Ugly Module 6: Danger Spots: Anger Cues and Triggering Events Module 7: Just Before the Storm: Feelings and Thoughts in a Flash Module 8: Challenging Yourself: Are Automatic Thoughts Automatically Right? Module 9: Showing Style: How do You Express Your Anger? Module 10: Cycles of Anger Module 11: Freeing Yourself from Rage (Part 1) Module 12: Freeing Yourself from Rage (Part 2) Module 13:Taking Responsibility and Self-Assessment Module 14: Your Long-Term Anger Management Plan	Group is designed for inmates with above average cognitive and reading skills. Self-assessment of change and treatment-readiness conducted at beginning and end of group permitting pre/post comparison. Because the modules gradually build on each other, it is preferable for participants to join the group at the beginning rather than later in the module series.

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TITLE/OBJECTIVE OF GROUP	STRUCTURE/FORMAT OF GROUPS	COMMENTS
ANGER MANAGEMENT GROUP (Average Functioning Inmates) Group provides a comprehensive set of cognitive and behavioral skills training modules that address maladaptive behavior patterns of responding to anger and risk factors for aggression. By the conclusion of the group, participants will have learned to: • Engage in three types of relaxation skills • Understand the adaptive role of anger in their lives, including its benefits and potential risks • Identify triggering events/situations that prompt anger • Identify automatic thoughts, attitudes and "self-talk" that contribute to anger • Search for and identify "primary" emotions that precede and contribute to anger • Self-monitor their anger and their coping techniques • Understand the consequences of anger in their lives • Learn 12 anger management techniques • Develop their own long-term anger management plan	Twelve group modules, each designed for one hour sessions with handouts and homework assignments. Module 1: Introduction and Self-Assessment Module 2: Learning to Rest Your Mind Module 3: Using Muscles and Imagination to Relax Module 4: Anger is an Emotion Module 5: Anger: The Good, the Bad and the Ugly Module 6: Danger Spots: Anger Cues and Triggering Events Module 7: Just Before the Storm: Feelings and Thoughts in a Flash Module 8: Challenging Yourself: Are Automatic Thoughts Automatically Right? Module 9: Freeing Yourself from Rage (Part 1) Module 10: Freeing Yourself from Rage (Part 2) Module 11: Taking Responsibility and Self-Assessment Module 12: Your Long-Term Anger Management Plan	Each group module is designed to take one hour. Each module begins with a review of the material covered in the previous session. It is recommended that group size be limited to 15 participants and that the group meet once a week. Quantitative self-assessment of change and treatment-readiness are conducted at beginning and end of the group permitting pre/post comparison. Because the modules gradually build on each other, it is preferable for participants to join the group at the beginning rather than later in the module series. Handouts are included for each module and homework is regularly assigned.

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TITLE/OBJECTIVE OF GROUP	STRUCTURE/FORMAT OF GROUPS	COMMENTS
DEALING WITH FEELINGS (High Functioning Inmates) Group provides a comprehensive set of cognitive and behavioral skills training modules that address: • Maladaptive behavior patterns of responding to negative emotions • Deficits in self-regulation and self-control • Risk factors for aggression and self-harm Each participant will receive comprehensive training in emotion regulation skills, including cognitive and behavioral and self-regulation skills, to reduce the influence of negative emotions and increase the influence of positive emotions on participants' behavior, reduce the risks for future aggressive or criminal behavior driven by negative emotions, and to improve quality of life.	Fifteen group modules, each designed for two hour sessions with handouts and homework assignments. Module 1: Introduction and Self-Assessment Module 2: Emotion Motion Module 3: Nine Families of Emotion; Starting out with Fear Module 4: Sadness and Shame Module 5: Contempt and Disgust Module 6: Envy and Jealousy Module 7: Automatic Thinking and Emotions Module 8: Primary and Secondary Emotions Module 9: Emotion Waves Module 10 Emotion Wildfires Module 11: Emotion Styles Module 12: Excitement and Joy Module 13: Changing How You Feel Module 14: Your Long-Term Emotion Regulation Plan Module 15: Self-Assessment, Self-Acceptance, and Changing	Group is designed for inmates with above average cognitive and reading skills. Important for group reader to read the program's overview prior to implementing. Material covered in Dealing with Feelings program ranges from quite basic to considerably difficult. Emotion regulation skills are challenging to teach, in part because participants tend to view the information and skills as either too childish or too hard. The modules attempt to achieve a reasonable balance, but much depends on the facilitator's tone and ability to communicate respect and flexibility towards the participants' individual emotional needs. Each group module is designed to take about two hours; it may be necessary to divide some modules into two sessions, depending on participants' speed of comprehension and the length of time devoted to group discussion. Quantitative self-assessment of change, and treatment-readiness are conducted at beginning and end of the group, permitting pre/post comparison. Because the modules gradually build on each other, it is preferable for participants to join the group at the beginning rather than later in the module series. Handouts are included for each module and homework is regularly assigned.
GRIEF SUPPORT GROUP Acknowledgement: This group was originally developed by Jan Burkemper, of Missouri Department of Corrections for MHM Clinical Ideas Contest in 2007. Thanks, Jan. The Grief Support psychoeducational group provides information about the grief experience and a setting in which group members may share their grief experiences and develop safe, healthy and effective coping strategies. Objectives: • To provide general information about the grief process • To learn about grief reactions to various situations • To explore coping mechanisms to grief reaction • To provide an environment for safe discussion of grief experiences • To explore ways to handle grief positively over time	Modules developed for group meeting once a week for 9 weeks. Because the modules build on each other, it is preferable for participants to join the group at the beginning rather than later in the module series. Module 1: Grief and Mourning Module 2: Grief Cycles and Reconciliation Module 3: Types of Grief Module 4: Communication with Others Module 5: Pain and Sadness: Confrontation and Escape Module 6: Grief and Anger Module 7: Grief and Guilt Module 8: Caring for Yourself Module 9: Reconciliation	The Grief Support Group should include from four to eight inmates. A small group is recommended to permit time for each member to express his/her story and discuss his/her feelings. Some of the group modules may take longer than 40 to 60 minutes, and can be split up into separate modules if needed. Three of the modules have homework assignments to be completed between sessions, and group members are encouraged to journal about their grief from the third session forward. All of the modules have handouts to facilitate psycho-education and discussion. In addition, you will need a flipchart or white board for several of the exercises.

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TITLE/OBJECTIVE OF GROUP	STRUCTURE/FORMAT OF GROUPS	COMMENTS
COPING WITH INCARCERATION The goal of the Coping with Incarceration group is to facilitate offenders adjusting to the environment of the correctional institution, as well as how to respond to family, friends and relatives they left behind when going to prison. <u>Objectives:</u> • To facilitate offender transition into the correctional environment by orienting the offender to the rules as well as the social environment of institutional living and aiding the offender in getting needs met in the institutional environment. • To facilitate an adaptation strategy that decreases the stress associated with the significant lifestyle change brought about by transitioning into a new and rule bound environment. • To maintain a connection with the community support system • To adjust to the change in roles within the institution from the role held before entry into the correctional setting • To introduce offenders to the idea that that they have choice in changing the circumstances which brought them to prison so they can avoid being imprisoned in the future.	Modules developed for group meeting once a week for 6 weeks Module 1: Learning the Rules and How to Use Them to Your Advantage Module 2: How to Get What You Need from the Institution Module 3: Maintaining Relationships and Parenting from a Distance Module 4: Communicating with People You Care About and Who Care About You Module 5: Making Plans for the Future/Planning + Action = Satisfaction Module 6: Coping Skills in a Correctional Environment	Group should include from eight to fifteen inmates.
RESPONSIBLE PARENTING Structured program designed to provide inmates the opportunity to improving parenting skills. The program consists of an introductory structured group and the distribution of handouts and worksheets about topics covered in the introductory group. It is recommended that the handouts and worksheets be reviewed at a second group session on the topic. Following the second group session, the inmates will be provided an open-book assessment to complete to reinforce the inmate's understanding of the unit's concepts.	The program includes 30 modules in the following 9 units: • Support • Empowerment • Boundaries and Expectations • Constructive Use of Time • Commitment to Learning • Positive Values • Social Competencies • Positive Identity • Anger Management	Responsible Parenting is structured to be offered both as a group and as in-cell programming. Groups should be limited to no more than 15 participants to facilitate group discussion of the psychoeducational programming and a forum for inmates to share their parenting experiences and plans for the future.

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TITLE/OBJECTIVE OF GROUP	STRUCTURE/FORMAT OF GROUPS	COMMENTS
COPING AND HOPING The Coping and Hoping group provides cognitive and behavioral skills training modules that assist inmates in developing skills to reduce and cope with chronic suicidal ideation and self-injurious behaviors. The group does not distinguish between self-injurious and suicidal behaviors. Despite the fact that intent and behavioral dynamics can sometimes be different between the two classes of behavior, research makes clear that the two types of behavior are more similar than different. For purposes of this group, interventions focus on both self-injurious/suicidal behaviors. <u>Objectives</u>: • Know how to ask for help before suicidal/self-injurious thinking gets strong • Identify the negative consequences of suicidal/self-injurious thinking and behaviors • Identify the situational triggers that increase their risks fo suicidal/self-injurious thinking and behavior • Identify the emotional triggers that increase their risks fo suicidal/self-injurious thinking and behavior • Avoid behaviors and thought patterns that increase their risks for suicidal/self-injurious thinking and behavior • Engage in behaviors and thought patterns that decrease their risks for suicidal/self-injurious thinking and behavio • Learn coping skills to manage emotional distress and behavioral impulsivity • Learn cognitive and behavioral skills to increase hope and long-term planning	Group includes discussion facilitated by handouts for the following seven modules: Module 1: Safety Comes First Module 2:Taking Yourself Hostage Module 3: What are Your Triggers? Module 4: Making Things Worse, Making Things Better Module 5: Two Types of Coping Module 6: Holding on to Hope Module 7: Sticking Together	This group is intended for inmates who have engaged in recurrent suicidal ideation and/or self-injurious/suicidal behavior. Whenever possible, participants should be well known to the mental health teams before joining this group. Inmates who participate in this group are at high risk. Although successful participation in this group is intended to reduce that risk, risk reduction is never guaranteed. It is therefore recommended that group leaders carefully monitor participants throughout the course of the group for nonverbal signs of agitation, anger, despondency and their opposite – sudden changes for the better, accompanied by a sense of peace or quiet resignation. The inmates who participate in this group need to be behaviorally stable and capable of participating in basic psychoeducational groups. This group is not intended for crisis management. Behavioral and psychiatric stability is a prerequisite for participation. Although the focus of the group is not on verbalizing suicidal ideation, participants must be able to acknowledge and discuss self-injurious/suicidal impulses without acting on them. Inmates who engage in self-injurious or suicidal behavior during the course of the group should be carefully evaluated for higher levels of care

INDEX TO GENERAL GROUP CURRICULUM MODULES (Effective May 2009)

TITLE/OBJECTIVE OF GROUP	STRUCTURE/FORMAT OF GROUPS	COMMENTS
LIFE AFTER RELEASE The Life After Release group provides cognitive and behavioral skills training modules that assist in planning for life after release for inmates approaching a release date. This release planning group is designed for the inmate who has sought mental health treatment during incarceration but is not designed to address the needs of those inmates with significant or serious mental illness. Another group offered by MHM, entitled *Planning for A Better Life* is designed to meet the needs of those individuals. The focus here is for participants to set realistic goals for themselves, be open to feedback about the feasibility of their expectations, and develop skills to both avoid negative influences and take advantage of positive ones. <u>Objectives</u>: • Identify realistic options that will help them to meet basic needs once they are released from prison. • Understand that their expectations and the reality they will face may not always be the same. • Use skills necessary to avoid situations that may harm them and may lead them back to prison. • Use skills necessary to take advantage of situations that may help them and keep them on a positive and healthy path. • Develop a realistic plan for return to the community	Because the modules gradually build on each other, it is preferable for participants to join the group at the beginning rather than later in the module series. Handouts are included for each module. Module 1: Introduction and Expectations Module 2: Housing and Money Module 3: Caring for Yourself Physically Module 4: Caring for Yourself Emotionally and Mentally Module 5: Avoiding the Negatives Module 6: Taking Advantage of the Positives Module 7: Defining Your Path Module 8: Wrap Up	During the first group session, each participant will be provided a list of the group rules and will sign and agree to all the terms of the admission agreement. They will also be introduced to two important concepts that will continue as the foundation for all groups: 1) You are solely responsible for yourself, and 2) Realistic goals are necessary for success. These concepts will be reinforced throughout the group but it is important to review them at the start of each group meeting as a means of reinforcing the concepts with the participants. Please feel free to add any resources that you may have at your disposal to assist inmates with their transition to the community. If you have resources which identify certain agencies or mental health centers within the community, provide these to the participants.

INDEX TO GENERAL GROUP CURRICULUM MODULES (Effective May 2009)

TITLE/OBJECTIVE OF GROUP	STRUCTURE/FORMAT OF GROUPS	COMMENTS
ADJUSTMENT SKILLS GROUP This group was originally developed in 2008 by Maria Masotta, Psy.D., Morgann McGinty, LCSW and Jen Korn, LCSW at Massachusetts Correctional Institute – Framingham. Some formatting and organizational changes have been made, but the original content and credit belong to the Framingham team. Many thanks, Maria, Morgann and Jen! The Adjustment Skills psychoeducational group provides information about ways inmates can address mood changes, irritability, anxiety and sleep problems that occur as part of the normal process of adjusting to incarceration. This group is designed for inmates who are new to prisons and jails. The primary purpose of this group is to provide non-pharmacological interventions for inmates experiencing stress and emotional adjustment problems. Building adjustment skills rather than relying on psychotropic medication is a major goal for this group. <u>Objectives</u>: • To provide general information about adjusting to incarceration • To learn and practice coping skills that can help in adjusting to changes, including to living in jail/prison • To address problems of moodiness, irritability, anxiety and sleep disturbance through non-medical interventions	Modules are designed for sessions to be conducted once a week, with participation by 6 to 15 inmates at a time. Because the modules build on each other, it is preferable for participants to join the group at the beginning rather than later in the module series. This group is psychoeducational in nature. It may not be the best forum for inmates to disclose personal issues or information. In some facilities, guided relaxation exercises are gathered in a binder, and the group leader chooses one of these exercises for each module, starting with Module 3. Module 1: Orientation and Seeing Where You Are Module 2: Stress and Stress Management Module 3: Relaxation and Sleep Skills Module 4: Positive Behaviors and Self-Talk Module 5: Mistaken Beliefs and Affirmations Module 6: Anger Management Module 7: Nonviolence, Assertive Communication and Wrap Up	If there is a need to complete this Adjustment Skills Group in less than seven weeks (e.g., at reception centers or jails), it possible is to combine Modules 2 and 3 and to combine Modules 6 and 7. When making these combinations, the group leader must be comfortable passing out a good deal of written material as homework rather than completing it in session. The Beck Depression and Beck Anxiety Inventories can be utilized as pre-/post-group evaluation to track program effectiveness. These copyrighted materials are not included in the Resource Manual and must be purchased through your contract if you use them.

INDEX TO GENERAL GROUP CURRICULUM MODULES (Effective May 2009)

TITLE/OBJECTIVE OF GROUP	STRUCTURE/FORMAT OF GROUPS	COMMENTS
ANXIETY GROUP The Anxiety Group provides participants with a set of cognitive and behavioral skills training modules that address: • Relaxation skills • Cognitive restructuring • Emotional expression <u>Group Objectives</u>: Each participant will receive education about anxiety and training in coping skills (including cognitive, emotional, and behavioral skills) to better manage the impact of anxiety and to improve the participant's overall quality of life. By the conclusion of the group, participants will have learned to: • Engage in three types of relaxation skills • Understand that anxiety is experienced in three parts • Self-monitor their anxiety and their coping techniques • Identify "self-talk" that contributes to anxiety • Develop alternative "self-talk" that decreases anxiety • Calm their bodies when they feel anxiety coming on • Identify and express feelings • Develop their coping plan to decrease anxiety	Each group module is designed to take one hour. Every module begins with a review of the material covered in the previous session. Due to the content of the group and the intended participants, it is recommended that group size be limited to 8 to 10 participants and that the group meet once a week. This group is cognitive-behavioral in content and tone. Although there is room for discussion and emotion in this group, this group is not intended to be a forum for emotional uncovering work or emotional catharsis. It is solution focused, not problem focused. At several points during the modules, instructors are reminded to maintain this cognitive focus and keep the sessions structured. Because the modules gradually build on each other, it is preferable for participants to join the group at the beginning rather than later in the module series. Handouts are included for each module. Module 1: Introduction and Basics Module 2: Breathing to Calm Your Mind Module 3: Using Muscles and Imagination to Calm Yourself Module 4: Three Parts of Anxiety Module 5: Self-Talk Module 6: STOP Negative Self-Talk Module 7: Sitting With Anxiety Module 8: Expressing Feelings Module 9: Summary and Self-Assessment Module 10: Wrap-Up & Make a Plan	Each participant will be introduced to five core guidelines that will continue as the foundation for all groups: 1. <u>Safety comes first</u>. To be successful in this group, the participant needs to remain safe. Active suicidal thinking and self-injurious behaviors are not safe. Remaining safe means being able to experience discomfort without becoming self-injurious or suicidal. 2. <u>Stay positive</u>. The participant needs to stay positive. The focus of the group is not on "war stories," competition, negative comparisons, fruitless complaining, or bitter rages. None of these behaviors will help the participant reach his/her goals. 3. <u>Focus on life</u>. The focus of the group is on improving participants' thinking and behavior. The participant needs to focus on his/her own goals and how to reach them. 4. <u>Stay responsible</u>. Participants are responsible for their own behaviors and feelings. The group will help participants take responsibility and take control over their negative states of mind. Ultimately, however, each participant is responsible for him/herself. 5. <u>Avoid therapy-interfering behaviors</u>. Self-injurious and suicidal behaviors are considered to be therapy-interfering behaviors and distractions from the goals of the group. When participants hurt themselves, they are interfering with making progress, and with their own therapy. Participants are in this group to get help. To get that help, participants need to avoid behaviors that interfere with treatment. In short, participants need to stay safe. This psychoeducational group module is designed to promote coping skills, hope, future-orientation, and long-term planning. This module is not designed as a stand alone intervention to address the needs of inmates who suffer from severe depression or require intensive behavioral and safety interventions. However, the group may be included as part of the treatment for inmates with these difficulties.

INDEX TO GROUPS/ACTIVITIES FOR CHALLENGED INMATES

(Effective April 2008)

TITLE/OBJECTIVE OF GROUP	STRUCTURE/FORMAT OF GROUPS	COMMENTS
ACCEPTING MENTAL ILLNESS Group is the first of a series of groups designed for the treatment of inmates with chronic mental illness. The group is designed to be fairly simple and concrete. Many individuals with chronic illness are easily frustrated and will give up if the material presented is too difficult. It is important to the success of the group process and individuals participating in these groups that there is a feeling of safety and of understanding and a feeling of being talked to and with and not demeaned.	Group includes discussion facilitated by handouts for the following 5 modules: Module 1: What is Mental Illness Module 2: You are Not a Mental Illness Module 3: No Less of a Person Module 4: Treatment Module 5: Trusting Your Treatment Team	This group was developed for inmates compromised by serious mental illness, typically the low functioning inmates on a mental health unit.
HANDLE ANGER BETTER (Challenged Inmates) Psychoeducational group provides cognitive and behavioral skills training modules that address anger management for inmates compromised by serious mental illness or limited cognitive abilities. By the conclusion of the group, participants will have learned to: • Engage in deep breathing as a form of relaxation • Understand the adaptive role of anger in their lives, including its benefits and potential risks • Identify triggering events and situations that typically prompt anger • Identify automatic thoughts, attitudes and "self-talk" that contribute to anger • Identify their typical style of dealing with anger • Understand the consequences of anger in their lives • Learn 12 anger management techniques • Develop their own long-term anger management plan to avoid aggressive and violent behavior	Group includes discussion facilitated by handouts for the following 10 modules: Module 1: Hello and Relax Module 2: What Is Anger? Module 3: How You Know When You're Angry Module 4: Things That Make You Angry Part One Module 5: Things That Make You Angry Part Two Module 6: How Do You Get Angry? Module 7: Does Anger Help or Hurt (or both)? Module 8: Handle Anger Better – Part One Module 9: Handle Anger Better – Part Two Module 10: Your Long-Term Anger Management Plan	This group was developed for inmates compromised by serious mental illness, typically the low functioning inmates on a mental health unit. Each module is designed to take 40 to 60 minutes. Each module begins with a review of the material covered in the previous session. It is recommended that group size be limited to 10-15 participants and that the group meet once a week. Because the modules gradually build on each other, it is preferable for participants to join the group at the beginning rather than later in the module series. Handouts are included for each module.

INDEX TO GROUPS/ACTIVITIES FOR CHALLENGED INMATES

(Effective April 2008)

TITLE/OBJECTIVE OF GROUP	STRUCTURE/FORMAT OF GROUPS	COMMENTS
PERSONAL HYGIENE The Personal Hygiene psychoeducational group provides cleaning and grooming skills training modules that address personal hygiene habits for the seriously mentally ill and cognitively limited inmate. The Personal Hygiene group is appropriate for inmates who have difficulties in maintaining their personal hygiene due to their mental illness.	Group includes discussion facilitated by handouts for the following 5 modules: Module 1: Taking Care of the Skin You're In Module 2: Grooming and Hygiene Skills Module 3: More Grooming and Hygiene Skills Module 4: Your Personal Space Module 5: Your Personal Cleanliness Plan	This group involves active "hands-on" training. Participants have no written homework. Instead, each group session concludes with a specific "challenge" to participants to complete particular cleaning and grooming skills during the next week. The expectation is that participants will practice hygiene skills both during the group sessions and afterwards. The group facilitator will need to model and demonstrate these skills during the group, and assist participants who are having difficulty with practicing the skills. The facilitator also must plan ahead to access cleaning and grooming supplies prior to each session. Participant handouts are provided for each module.
PLANNING FOR A BETTER LIFE Group was developed for inmates compromised by serious mental illness, typically, low functioning inmates on a mental health unit who are preparing for release form prison. Objectives: • To provide forum for inmates compromised by serious mental illness to discuss how to meet their basic needs and personal goals when released from incarceration. • To assist inmates in understanding the importance of setting up and maintaining a healthy and balanced lifestyle. • To teach some of the skills necessary in meeting basic needs and personal goals.	Group includes discussion facilitated by handouts for the following six modules: Module 1: What are Your Needs? Module 2: Where Do I Want to Live? Module 3: Activities of Daily Life Module 4: Taking Care of Myself Module 5: Do I Want a Job? Module 6: Wrap Up	This group is designed to be supplemented with additional materials available within your contract. For example, if all of your participants are going to apply for Social Security Income or Disability, you can dedicate a group session to completing applications. If you have specific names of clinics or resources, make them available to participants. Invite other professionals to come to group and assist. Activity and recreational therapists can be a great resource for Module 3.

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(Effective April 2008)

TITLE/OBJECTIVE OF GROUP	STRUCTURE/FORMAT OF GROUPS	COMMENTS
SELF-ESTEEM FOR CHALLENGED INMATES Goal of the Self-Esteem for Challenged Inmates group is to assist inmates compromised by mental illness or cognitive impairments to learn about the concepts of high and low self-esteem and to learn ways to improve their self-esteem. Another goal is to assist the inmates in participating in a structured group situation in an appropriate manner. <u>Objectives:</u> • To introduce the concept of self-esteem and how high/low self esteem can impact one's life • To introduce the idea that exercise, eating habits and sleeping patterns can impact self-esteem • To briefly review the concepts of identity, appreciation, acceptance, self-confidence, pride and humility, and how these concepts are related to self-esteem • To review the concepts of unconditional worth and unconditional love • To introduce the concept of growing as a person and how "growing" might affect one's self esteem? • To introduce the concept of even though-nevertheless statements and how to replace because-therefore statements with even though-nevertheless statements • To discuss the concept of failure versus the concept of setback • To introduce ways to learn from and cope with setbacks • To introduce concept of distorted thinking and how distorted thinking can impact self-esteem • To practice changing distorted thinking • To explore ways to increase self-esteem while in prison	Group includes discussion facilitated by handouts for the following 12 modules: Module 1: What is Self-Esteem? Module 2: Effect of Exercise, Eating & Sleeping on Self-Esteem Module 3: Seven Concepts Related to Self-Esteem Module 4: Unconditional Worth Module 5: Unconditional Love Module 6: Growing as a Person Module 7: Even Though-Nevertheless Statements Module 8: Failures or Setbacks Module 9: Handling Setbacks Module 10: Distorted Thinking Module 11: Changing Distorted Thinking Module 12: Improving My Self-Esteem	Group should include from six to eight inmates.

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(Effective April 2008)

TITLE/OBJECTIVE OF GROUP	STRUCTURE/FORMAT OF GROUPS	COMMENTS
EXPLORING THE UNITED STATES The goal of the Exploring the United States group is to assist inmates compromised by mental illness or cognitive impairments to learn about the United States in a non-threatening manner that will increase self-esteem through learning. Another goal is to assist the inmates in participating in a structured group situation in an appropriate manner. Objectives: • To review information about the states in the United States: location, capitals, size • To provide "games" in which learning information about the states is rewarded with recognition • To allow each participant to learn about a specific state and share this information with the group • To have each participant plan a "trip" to his/her chosen state and share experience with the group • To provide opportunity for group members to interact around topics of general interest	Group Structure: While the initial modules of the group are structured around general information about the United States, structure of later sessions will be determined by the level of information each group member is able to share about his/her chosen state or "trip" to the chosen state. Information about the specific states will be requested from the state. Module 1: What Do You Know About the States? Module 2: State Capitals Module 3: Size of the States Module 4: Abbreviations for the States Modules: My Chosen State (group member presentation) Modules: A Trip I Would Like to Take (group member presentation)	Group will require the group leader to work individually with the group members as they gather information and prepare presentations on their "chosen states" and "trip plans." This can occur during "working" group sessions or outside of group time.

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(Effective April 2008)

TITLE/OBJECTIVE OF ACTIVITY	MATERIALS REQUIRED	COMMENTS
Activity: ALBUM COVERS • To foster appropriate self expression using art • To stimulate thought and discussion of past, present future • To provide opportunity for social interaction	Construction Paper in a variety of colors Markers, crayons, pencils Magazines that may be cut apart Glue Safety scissors	
Activity: CHANGE/FALL LEAVES • To provide reality orientation to Fall season of the year • To gain insight into change, and the cycles and patterns in life • To practice appropriate group behavior and discussion skills	Bulletin board or large (banner size) paper Crayons, markers, pencils Scotch tape or stapler Leaves and heavy paper to cut out in the shape of leaves. If scissors are not permitted, staff can have leaves cut out for the inmates (samples attached)	
Activity: I JUST CALLED • To foster appropriate self-expression • To stimulate interaction with peers	CD or tape of "I Just Called To Say I Love You" by Stevie Wonder Handout: "I Just Called to Say I Love You" Handout: Conversation Bubbles A large telephone drawn on paper and hung on wall or bulletin board Crayons, markers, pencils Scotch tape or stapler	
Activity: MASKS • To promote positive, appropriate self-expression • To explore, identify and gain insight into our moods, feelings and how we express them • To practice appropriate group behavior and discussion skills	Handout: Man with Two Masks Cutouts of small masks that can cover the masks in the handout Markers, crayons or pencils Scotch tape or stapler	
Activity: SOCIAL SKILLS • To learn new skills to get along • To learn new approaches to difficult situations • To learn how to express self in a positive manner	Four poster boards prepared by leader Handout: Social Skills	This group needs to be conducted by two staff who can role-play and coach the group members. Staff will be using modeling, reinforcement and repetition to help the group members learn the new skills. Depending on the size of the group, this activity may require more than one session to be effective.

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(Effective April 2008)

TITLE/OBJECTIVE OF ACTIVITY	MATERIALS REQUIRED	COMMENTS
Activity: TOPPLING ROADBLOCKS • To practice problem solving skills • To prioritize goals/needs • To stimulate social interaction	Handout: Toppling Roadblocks Markers, crayons, pencils or pens	
Activity: ZIP ZAP ZOP GAME • To learn appropriate social interaction • To practice reality-based communication • To improve concentration and attention span • To have fun	None	

MHM CLINICAL GUIDELINES
PSYCHOLOGICAL SERVICES

Mental Health Consultation to the Disciplinary Process

MHM model policy requires mental health staff to provide relevant consultation to the disciplinary process for inmates with serious mental illnesses who receive a disciplinary report. Such consultation involves consideration of:

- The presence of serious mental illness
- The nature of the inmate's illness
- The inmate's treatment and medication compliance
- The inmate's current mental status and impact on inmate's ability to participate in the due process disciplinary hearing
- If inmate is found unable to participate in the disciplinary hearing, treatment measures to be taken to restore ability
- The role of mental illness in the rule-breaking behavior that led to the disciplinary charge
- Treatment consequences of possible dispositions if the inmate is found guilty
- If clinically indicated, request for mental health staff to be present at hearing

It is MHM's policy that, while inmates will not be punished for symptoms of a serious mental illness, inmates with serious mental illness are not exempted from complying with institutional rules and regulations.

Specific elements of the Mental Health Consultation follow the policies and procedures of the client. NCCHC does not currently require mental health consultation to the disciplinary process with regard to competence or responsibility. NCCHC does require that qualified healthcare staff review the inmate's record to determine whether existing medical, dental, or mental health needs contraindicate placement in segregation or require accommodation. Separate Guidelines supporting this step are available.

Little guidance is available from the NCCHC and ACA regarding the process of completing Mental Health Consultation to the disciplinary process. The following Guidelines have been developed in an attempt fill this gap. When these Guidelines conflict with client policy and procedures with regard to scope or content, staff should be guided by the client's policy and procedures. Any ethical concerns regarding the inmate's care and custody should be addressed and resolved through consultation with supervisors and facility administration.

MHM staff completing these Mental Health Consultations should be independently licensed and have experience providing mental health services in correctional environments. In most cases, mental health staff who are already involved in the treatment of the inmate should complete these assessments, due to their greater knowledge of the inmate's treatment needs and history.

MENTAL HEALTH CONSULTATION TO THE DISCIPLINARY PROCESS
CLINICAL GUIDELINES – PSYCHOLOGICAL SERVICES

This document was created to serve as a guideline for completion of mental health consultations to the disciplinary process. MHM staff complete mental health consultations to the disciplinary process to meet standards set by the client when this task falls within the scope of MHM's contract. If these guidelines conflict with local policy or expectations, staff should be guided by local policy. Any ethical concerns that arise during the course of the consultation must be addressed and resolved through consultation with supervisors and facility administration.

DEFINITION

A Mental Health Consultation to the disciplinary process is a specialized assessment that occurs after an inmate with serious mental illness receives a disciplinary report. The consultation requires consideration of the inmate's ability to participate in disciplinary proceedings and the role that mental illness may have played in the behavior that gave rise to the disciplinary charge. The primary goals of these Consultations are to: 1) verify that inmates have the ability to participate in the disciplinary hearing; and 2) help guard against vulnerable inmates being punished for symptoms of serious mental illness, while simultaneously supporting accountability and responsibility for disciplinary infractions.

LIMITS OF SCOPE AND INTENT

Mental Health Consultations to the disciplinary process are limited to inmates with severe mental illness or brain damage and are not exhaustive forensic evaluations. These consultations must be completed promptly and efficiently, within one day of receipt of referral. These Guidelines are not intended to expand the scope of contractually required Mental Health Consultations. Evaluation of possible contraindications to placement in segregation and consideration of alternative sanctions are covered in separate Guidelines.

ETHICAL CONSIDERATIONS

Mental Health Consultations to the disciplinary process may raise concerns regarding the disciplinary process and/or the conditions of confinement for inmates with serious mental illness. The role of mental health staff in these Consultations is not to advocate for, protect, or punish the inmate. Mental health staff provide objective expert consultation to the disciplinary hearing officer and involved stakeholders. In most cases, it is preferable for mental health staff who are closely involved in the inmate's mental health treatment to complete the Mental Health Consultation to the disciplinary process. The knowledge that treatment providers have with regard to the inmate's history, mental illness and behavior is a valuable source of information for these consultations. If treatment staff were directly involved in the incident (e.g., as victims of an assault), the consultation should be completed by other mental health staff. When mental health staff's presence at the disciplinary hearing is indicated, mental health staff serve as expert consultants to the disciplinary process, and not as advocates for the inmate or the use of punishment.

PROCEDURE

Recommendations: Mental Health Consultations to the disciplinary process should be completed by independently licensed mental health staff. These staff should be trained in completing these assessments and experienced in providing correctional mental health care. As with all assessments, Mental Health Consultations should be completed in as objective, balanced and nonjudgmental manner as possible. Referrals for these assessments should be considered urgent, and the consultation should be completed within one working day of receipt of referral.

I. **Sources of Information.** Staff should utilize relevant available sources in gathering data for the Mental Health Consultation. Relevant sources include the mental health record, incident report, disciplinary report, referral from the disciplinary officer, and knowledge of the inmate based upon providing mental health treatment. In most cases, the Consultation can be completed without a face-to-face interview with the inmate, based upon knowledge of the inmate's mental health. In ambiguous cases, a focused interview with the inmate may be needed. In such cases, review of documentation prior to interviewing the inmate is recommended.

II. **Introduction and Orientation.** If an interview with the inmate is needed for purposes of this Consultation, the interview should take place in a private interview setting. The inmate should be informed about the nature of the Consultation and interview, the limits of confidentiality, and the fact that participation is voluntary.

III. Mental Health Diagnoses. A review of diagnostic impressions is helpful. If the inmate does not have severe mental illness or brain damage, there is little need to proceed further with this assessment. Custody staff can be notified that the inmate is able to participate in the hearing.

IV. Ability to Participate in Disciplinary Hearing. Even in the presence of active symptoms of severe mental illness, an inmate may have the ability to participate in his/her disciplinary hearing. The threshold for this ability is low: the inmate must understand the disciplinary charge(s) and be able to participate in the disciplinary process without significant interference from mental illness. Answering the following questions can assist in determining whether the inmate has the ability to participate in the disciplinary hearing:

- Does the inmate have a factual understanding of what his/her disciplinary charges are?
- Does the inmate understand that a hearing officer considers the evidence and makes a ruling?
- Does the inmate understand that he/she may plead not guilty or guilty?
- Does the inmate understand the likely consequences of being found guilty (e.g., segregation)?
- Can the inmate participate in his/her own defense without interference from mental illness?
- Can the inmate interact in a socially appropriate and coherent manner?

If the inmate does not have the ability to participate in the disciplinary hearing, the hearing must be postponed. Recommend specific treatment that is needed to restore the inmate to competence. If such restoration is unlikely (e.g., due to brain damage or dementia), describe the conditions that limit the likelihood of restoration.

V. Role of Severe Mental Illness. Even in the presence of active symptoms of severe mental illness, an inmate's behavior may simply be antisocial in nature. A finding that symptoms of mental illness played a role in the inmate's behavior requires a link between the symptom and the disciplinary infraction. Consideration of the inmate's compliance with treatment can be relevant, because noncompliant inmates with severe mental illness are more likely to have active symptoms that interfere with the ability to participate in disciplinary hearings, the ability to follow institutional rules, or both. Answering the following questions can assist in determining whether the inmate's mental illness contributed to the rule-breaking behavior:

- Was the inmate behaving in response to hallucinations or delusions?
- Was the inmate behaving in response to other symptoms of severe mental illness, such as dissociation, disorientation or mania?
- Was the inmate unable to understand the nature of his/her actions?
- Was the inmate unable to control his/her impulses?

Note that these questions need to be considered with respect to inmate's mental status at the time of the behavior. The inmate's mental status at the time of the Consultation may differ significantly from that at the time of the underlying behavior.

VI. Recommendations. As noted at step IV, if the inmate does not appear to have the ability to participate in the disciplinary hearing, it is incumbent on the mental health staff to recommend (1) postponement of the hearing and (2) treatment to restore the inmate's ability to participate in the hearing. Similarly, if symptoms of mental illness were identified as contributing to the inmate's behavior at the time of the disciplinary infraction, it is important to recommend treatment to reduce the inmate's risk of future disciplinary infractions. Mental health staff may also determine that their presence at the disciplinary hearing is appropriate, in order to provide additional consultation at the hearing regarding the inmate's treatment needs. Special treatment recommendations may also need to be made if the inmate is found guilty and placed in segregation.

VII. Documentation. In most cases, correctional systems have already developed templates to be used for documenting the Mental Health Consultation to the disciplinary process. Where such templates are lacking, a model form can be found in MHM Clinical Operations' Resource Manuals and modified to meet the specific needs of the client's policies and procedures.

JOB DESCRIPTION: DRAFT

Title: **Administrative Assistant**

Program:

Department:

Summary of Position: Under the supervision of the Program Director. Supervises the administrative, clerical and recordkeeping functions of the Program

Responsibilities:

1. Serves as the administrative liaison between the Program. the Regional Office and other Programs.
2. Trains Program personnel in administrative and recordkeeping procedures and systems.
3. Establishes and maintains files and filing system.
4. Initiates and processes purchase requisitions for approval and purchase order numbers. Obtains purchase order numbers in emergency situations.
5. Establishes and maintains client flow records and communicates daily movement to Administration Support.
6. Maintains an inventory of office supplies. forms. :Ind equipment
7. Expedites the processing of all 'Personnel Forms for employees.
8. Assists in training and orientation of new staff.
9. Maintains copies of pertinent Program personnel records and provides for their security.
10. Responds to routine inquiries for the Program Director. Makes outside contacts for purpose of relaying or obtaining information, arranges speaking engagements and Program tours.
11. Performs other tasks as assigned.

Qualifications:

1. High school education
2. Good verbal and written communication skills.
3. Knowledge of office and equipment, including basic computer programs, word, excel and power point.
4. Must comply with security clearance protocol.

JOB DESCRIPTION: DRAFT

Title: **Clinical Supervisor**

Program:

Department:

Summary of Position: Under the direct supervision of the Program Director, responsible for client files and the clinical functions of the treatment program. Responsible for the direct supervision of the counseling staff. Oversees the clinical evaluation, treatment planning, referrals, case management, counseling, documentation, education and ethical standards for program participants.

Responsibilities:

1. Supervises, manages, guides, and evaluates counseling staff. Participates in orientation and training for treatment and security personnel.

2. Responsible for training counseling staff. Provides seminars and workshops. Arranges for training by other agencies/providers as available.

3. Conducts weekly group supervision and case management for counselors and conducts weekly individual supervision with counselors. Monitors all treatment plan development, and substance abuse services coordination plans for continued community based substance abuse services upon release.

4. Audits client files to ensure compliance with required State and Federal guidelines.

5. Reviews and signs case management paperwork.

6. Oversees scheduling, and delivery of services to all program participants; responsible for planning type and frequency of client activities.

7. Supervises and reviews the selection and application of therapeutic techniques designed to modify client behaviors.

8. Supervises assignment of client caseload for each counselor

9. When a counselor is absent, assumes supervision for that counselor's caseload and functional responsibilities.

10. Assists the Director in establishing monthly staff schedule, and staff seminar schedule.

11. Responsible for client assessment in matters dealing with modification of sentence, parole hearings, etc.

12. Acts as the liaison with departmental custody and classification staff, and participates in the inmate classification hearings.

13. Supervises the administration of the assessment process of all newly arrived inmates.

14. Investigates and acts on client complaints.

15. Ensures client confidentiality and rights are maintained and is responsible for the secure storage of all participant records.

16. Assists in the development of policies and procedures for the program, and helps to maintain the procedure manual.

Qualifications:

1. Masters degree in Social Work or a related field. or two (2) cumulative years of full time experience supervising counseling staff in a substance abuse program for the criminal justice population

2. Is a Certified Drug and Alcohol Counselor. Preferred to have experience working in the Criminal Justice System.

3. Knowledge of substance abuse, and the ability to demonstrate clinical competencies including clinical evaluation, treatment planning, referral, case management, counseling, documentation, and ethical responsibility.

4. Experience in a therapeutic community preferred.

5. Must comply with security clearance protocol

6. If in recovery or an ex-offender, must be sober and crime free for at least three years.

JOB DESCRIPTION: DRAFT

Title: **Counselor**

Program:

Department:

Summary of Position: Under the supervision of the Clinical Supervisor, the counselor provides clinical evaluation, treatment planning, referral, case management, counseling, documentation, and education services to clients.

Responsibilities:

1. Completes screening and assessments to determine the most appropriate initial course of action, and to plan treatment and evaluate ongoing client progress.

2. Develops and implements a written treatment plan in collaboration with the client, which outlines desired treatment outcomes and identifies strategies to achieve them.

3. Facilitates through professional relationships and referrals to courts or agencies, the client's utilization of available support systems and community resources to meet identified needs.

4. Participates in case management services including implementing and coordinating activities related to the treatment plans and the substance abuse services coordination plans; consulting with the Clinical Supervisor Re-Entry Case Manager and clinical staff in a multi disciplinary treatment team; and continuing assessment and treatment planning. This includes coordination with community agencies, as well as significant others and site visits as indicated.

5. Participates in the selection and application of therapeutic techniques designed to modify behavior.

6. Provides individual counseling, group counseling and counseling for families/couples which facilitates the client’s progress toward treatment goals.

7. Provides information on risks, prevention, treatment, and recovery resources related to alcohol and other drug use through seminars and daily program activities.

8. Documents in client charts including recording the screening and

intake process, assessment information, treatment plans, preparation of written reports, clinical progress notes, discharge summaries and other client related data as required by State/Federal licensing agencies.

9. Adheres to ethical and behavioral standards of conduct and participates in continuing professional development seminars, workshops, or training sessions to increase knowledge and enhance job skills.

10. Ensures that client confidentiality and rights are maintained.

11. Maintains the health and safety of client's staff members and visitors.

Qualifications:

1. Addiction Counselor Certification or in the process of obtaining certification in substance abuse treatment.

2. Minimum of a High School Diploma or equivalent.

3. B.A. or equivalent experience preferred.

4. Experience in a therapeutic community preferred.

5. Must comply with security clearance protocol.

6. If recovering or an ex-offender, must be sober and crime free for at least three years.

7. Knowledge of substance abuse and the ability to demonstrate clinical competencies including clinical evaluation, treatment planning, referral, case management, counseling, documentation, and ethical responsibility.

JOB DESCRIPTION: DRAFT

Title: **Case Manager**

Program:

Department:

Summary of Position: Under the supervision of the Program Manager, is responsible for the screening of offenders who may be appropriate for placement in the KEY and or Crest Drug Treatment Programs.

Responsibilities:

1. Participates in appropriate DDOC classification meetings to assist in identifying offenders for the KEY and Crest Programs.
2. Interfaces with DOC classification staff at each institution to facilitate identifying appropriate offenders for treatment.
3. Maintains a list of eligible candidates and coordinates with DDOC to ensure that eligible candidates are placed in the appropriate treatment program based on clinical indicators.
4. As part of screening process completes an UNCOPE on potential candidates for treatment.
5. Maintains ongoing contact DDOC Internal Classification Committee Members to facilitate identifying offenders for treatment
6. In coordination with institutional administration provides presentations on KEY and Crest Programs to offenders who may benefit form treatment.
7. Prepares reports; maintains statistical and other records as required.

Qualifications:

1. Knowledge of substance abuse, and the ability to demonstrate clinical competencies including clinical evaluation, treatment planning, case management, counseling, documentation and ethical responsibility.
2. Three (3) years experience in substance abuse treatment/community corrections.
3. Licensed or certified chemical dependency counselor or eligible certification.

4. TC experience preferred.
5. Must comply with security clearance protocol.
6. If in recover or ex-offender, must be sober and crime free for at least three years.
7. Bachelors Degree in Behavioral Science preferred.

JOB DESCRIPTION: **DRAFT**

Title: **Program Director**

Program:

Department:

Summary of Position: Under the general supervision of the State Wide Substance Abuse Coordinator, manages-the clinical and administrative operations of the MHM treatment program, and assumes overall administrative responsibility for the delivery of program services.

Responsibilities:

1. Recommends the hiring and/or termination of program staff.
2. Supervises the Clinical Supervisor, Re-Entry Case Manager, Counselors, and Administrative Assistant: evaluates staff performance.
3. Implements all program policies and procedures; insures compliance with security regulations and procedures.
4. Recommends any policy or procedure changes designed to increase the effectiveness of the program.
5. Establishes and maintains good working relationship with the administration and staff of the institution.
6. Serves as liaison with Wardens, Judges, Probation/Parole Departments and other public/private agencies.
7. Insures that staff orientation and training needs are addressed and provides reports to the DDOC.
8. Reviews client treatment planning to assure quality of care.
9. Maintains client confidentiality and client rights.
10. Recommends expenditures necessary to support program activities; approves expenditures of the program.
11. Prepares monthly reports for program operations.

12. Maintains the health and safety of clients, staff members, and visitors.

13. Coordinates invoices, and submits monthly reports.

14. Manages the placement of in-prison graduates into community treatment programs.

Qualifications:

1. The Program Director must be Certified Alcohol & Drug Counselor (CADAC) If not certified the Program Director must be approved by DDOC and become certified within one year.

2. Knowledge of substance abuse and the ability to demonstrate clinical competencies including clinical evaluation, treatment planning, referral, case management, counseling, documentation, and ethical responsibility.

3. Prior experience in a supervisory position preferably in the criminal justice system

4. Therapeutic community experience required.

5. Must comply with security clearance protocol.

6. If recovering or an ex-offender, must be sober and crime free for at least three years.

JOB DESCRIPTION: DRAFT

Title: **Re-Entry Case Manager**

Program:

Department:

Summary of Position: Under the supervision of the Program Director, is responsible for the coordination of the transition of each client to community base treatment program.

Responsibilities:

1. Participates in case management meetings as clients progress through treatment.
2. Facilitates individual and group sessions for re-entry phase client.
3. Responsible for the coordination of the Case Management Meeting to develop the Substance Abuse Services Coordination plan for each client.
4. Completes client assessment for community transition treatment planning.
5. Maintains ongoing contact with client and community program after transition to the community.
6. Serves as the primary contact person with Probation/Parole representative, and the community base aftercare providers.
7. Provides substance abuse education to clients, families, and community.
8. Identifies and develops community base program contact to meet the needs of program clients.
9. Utilizes knowledge and resources to assist clients with problems that may arise in areas such as housing, emergency services, transportation.
10. Refers clients to appropriate available resources.
11. Works with and provides training to community-based treatment providers, especially those providing culturally appropriate services, on the TC model and on the special needs and issues of incarcerated individuals.
12. Prepares reports; maintains statistical and other records as required.

Qualifications:

1. Knowledge of substance abuse, and the ability to demonstrate clinical competencies including clinical evaluation, treatment planning, case management, counseling, documentation and ethical responsibility.

2. Three (3) years experience in substance abuse treatment/community corrections.

3. Licensed or certified chemical dependency counselor or eligible certification.

4. TC experience preferred.

5. Must comply with security clearance. protocol.

6. If in recover or ex-offender, must be sober and crime free for at least three years.

7. Bachelors Degree in Behavioral Science preferred.

JOB DESCRIPTION: DRAFT

Title: **Senior Counselor**

Program:

Department:

Summary of Position: Under the direct supervision of the Clinical Supervisor, responsible for the supervision of assigned counselors. Responsible for client files and the clinical functions of the treatment program for those counselor caseloads and for own caseload. Oversees the clinical evaluation, treatment planning, referral, case management, counseling, documentation, education, and ethical standards for program participants.

Responsibilities:

1. Completes screening and assessments to determine the most appropriate initial course of action, and to plan treatment and evaluate ongoing client progress.

2. Develops and implements a written treatment plan in collaboration with the client, which outlines desired treatment outcomes and identifies strategies to achieve them.

3. Facilitates through professional relationships and referrals to courts or agencies, the client's utilization of available support systems and community resources to meet identified needs.

4. Participates in case management services including implementing and coordinating activities related to the treatment plans and the substance abuse services coordination plans; consulting with the Clinical Supervisor, Re-Entry Case Manager, and clinical staff in a multi disciplinary treatment team; and continuing assessment and treatment planning. This includes coordination with community agencies, as well as significant others and site visits as indicated.

5. Participates in the selection and application of therapeutic techniques designed to modify behavior.

6. Provides individual counseling, group counseling and counseling for families/couples which facilitates the clients progress toward treatment goals.

7. Provides information on risks, prevention, treatment, and recovery resources related to alcohol and other drug use through seminars and daily program activities.

8. Documents in client charts including recording the screening and intake process, assessment information, treatment plans, preparation of written reports, clinical progress notes, discharge summaries and other client related data as required by State/Federal licensing agencies.

9. Adheres to ethical and behavioral standards of conduct and participates in continuing professional development seminars, workshops, or training sessions to increase knowledge and enhance job skills.

10. Ensures that client confidentiality and rights are maintained.

11. Maintains the health and safety of clients, staff members and visitors.

Qualifications:

1. Addiction Counselor Certification or in process of obtaining certification in substance abuse treatment in criminal justice settings by an accredited institution.

2. Three years experience in the field preferred.

3. B.A. or equivalent experience preferred

4. Knowledge of substance abuse and the ability to demonstrate clinical competencies including clinical evaluation, treatment planning, referral, case management, counseling, documentation, and ethical responsibility.

5. TC experience preferred

6. Must comply with security clearance protocol.

7. If recovering or an ex-offender, must be sober and crime free for at least three years.

JOB DESCRIPTION: DRAFT

Title: **Statewide Substance Abuse Program Manager**

Program:

Department:

Summary of Position: Under the general supervision of the MHM Regional Director assumes clinical and administrative responsibility for MHM Delaware programs.

Responsibilities:

1. Manages and coordinates all TC correctional services for the Delaware Programs.

2. Provides Supervision to ensure treatment capacity is achieved on ongoing basis

3. Reviews client treatment planning to assure quality of care.

4. In consultation with the Program Directors, recommends to the Regional Director the hiring and for termination of program staff.

5. Reviews all staff performance evaluations.

6. Insures that staff and security personnel training are completed.

7. Implements all program policies and procedures, and insures compliance with the Delaware Department of Correction regulations and procedures.

8. Advises the Regional Director, DDOC Director of Substance Abuse Services, and other corrections officials of any recommendations to increase the effectiveness of the program.

9. Works with the administrative office and directs regional budget preparation.

10. Recommends expenditures necessary to support program activities to the Regional Director and approves all expenditures submitted by the programs.

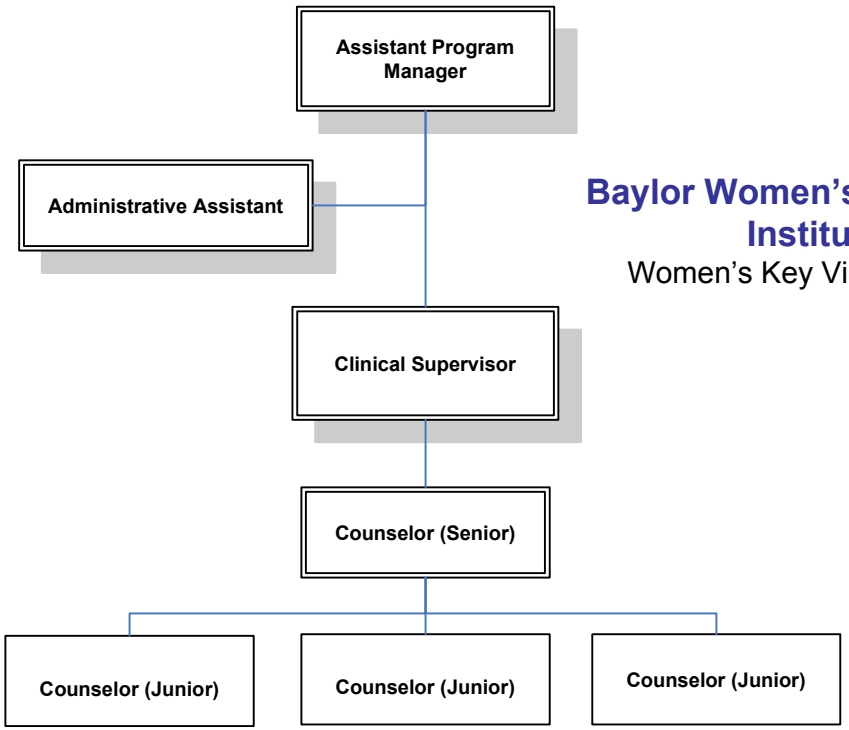
11. Submits monthly progress reports to the Regional Director.

12. Establishes and maintains a good working relationship with institutional personnel.

13. Maintains the health and safety of clients, staff and visitors.

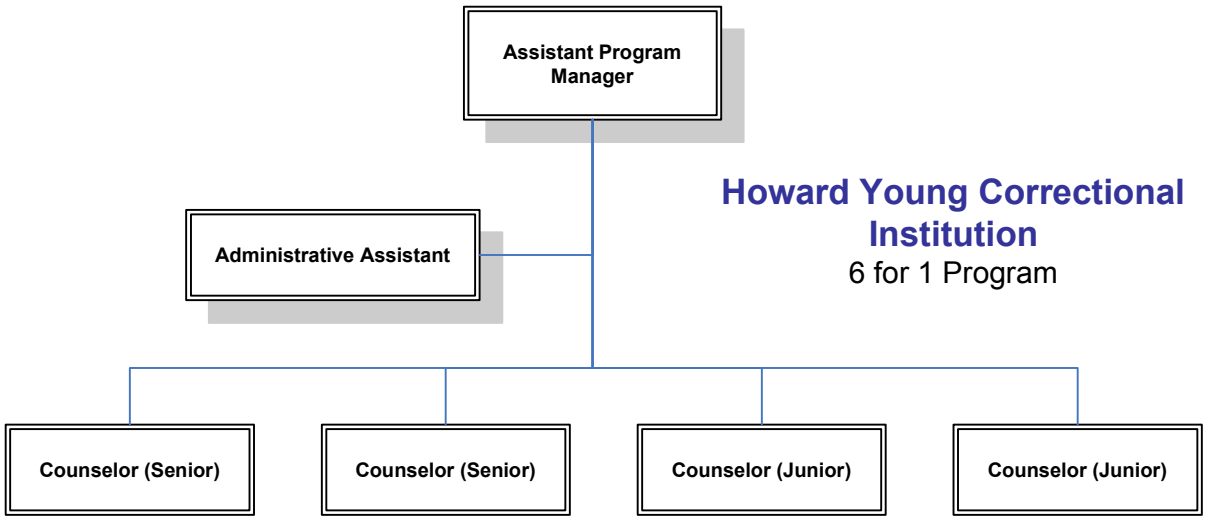
Qualifications:

1. Eight (8) years experience in the field and five (5) years supervisory experience preferred.
2. Bachelors Degree/ Master Degree preferred.
3. Drug and alcohol certification preferred
4. Knowledge of substance abuse, mental health, therapeutic communities and rehabilitation techniques including clinical evaluation, treatment planning, referral, case management, counseling, documentation and ethical responsibility.
5. Must demonstrate the ability to work with considerable independence in accordance with established regulations and procedures.
6. Must comply with security clearance protocol.
7. If in recovery or an ex-offender, must be sober and crime free for at least three years



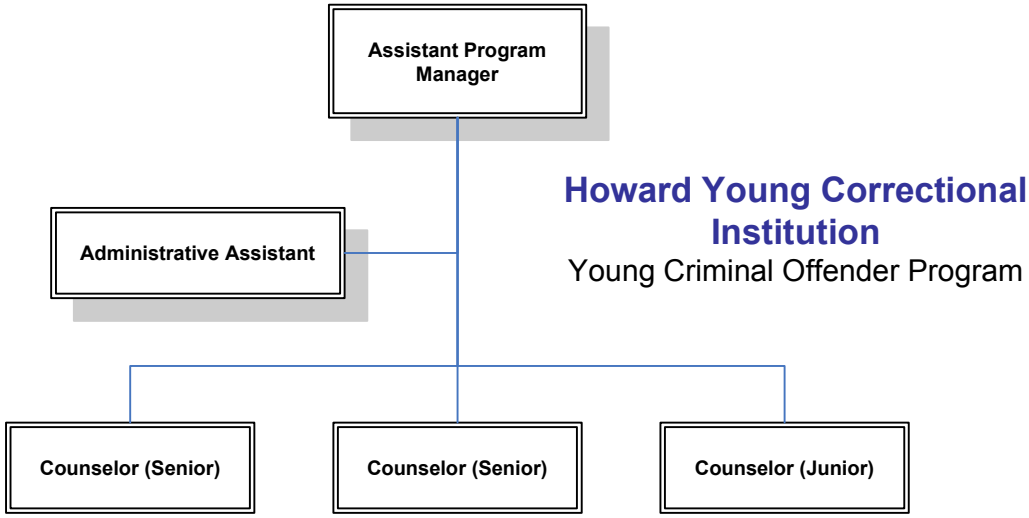
Baylor Women's Correctional Institution

Women's Key Village Program



Howard Young Correctional Institution

6 for 1 Program

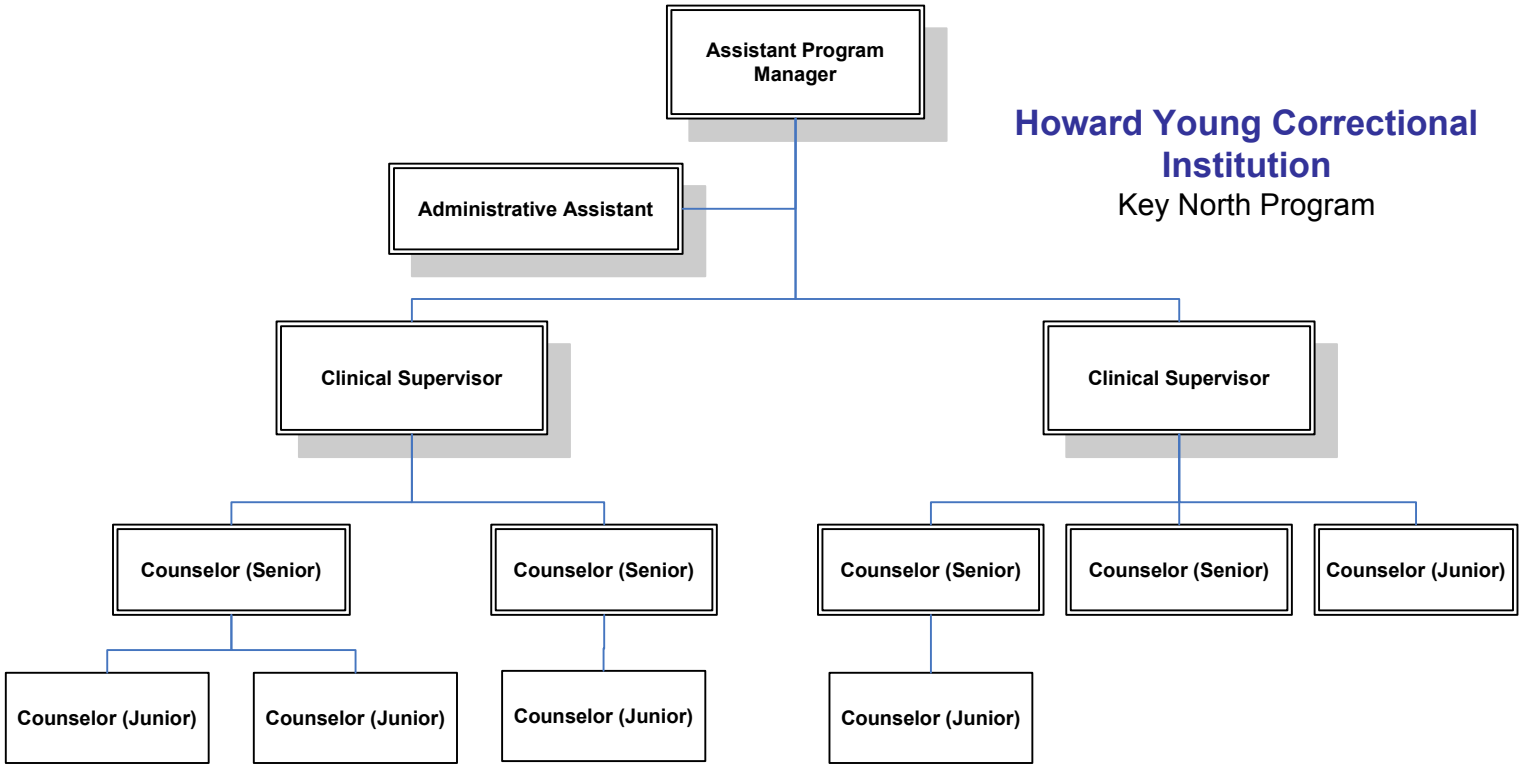


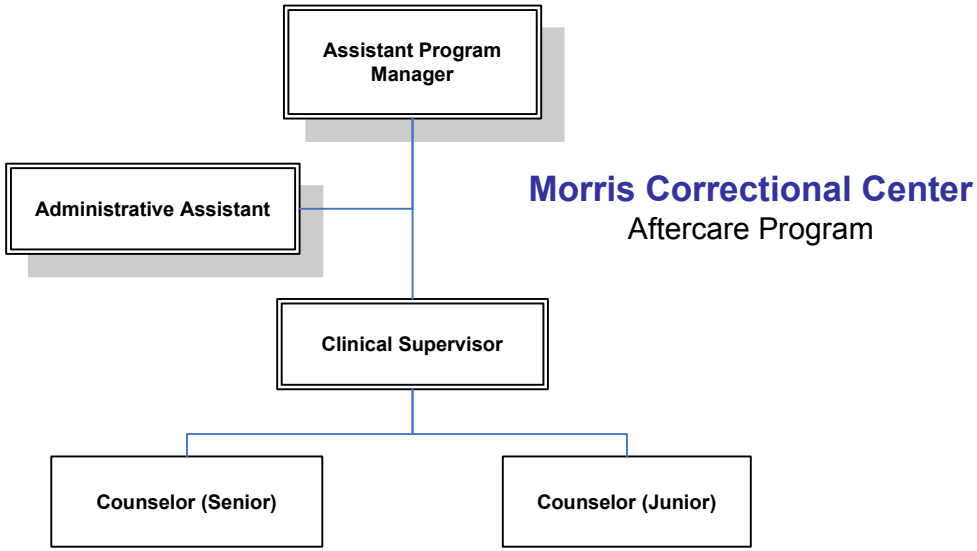
Howard Young Correctional Institution

Young Criminal Offender Program

Howard Young Correctional Institution

Key North Program



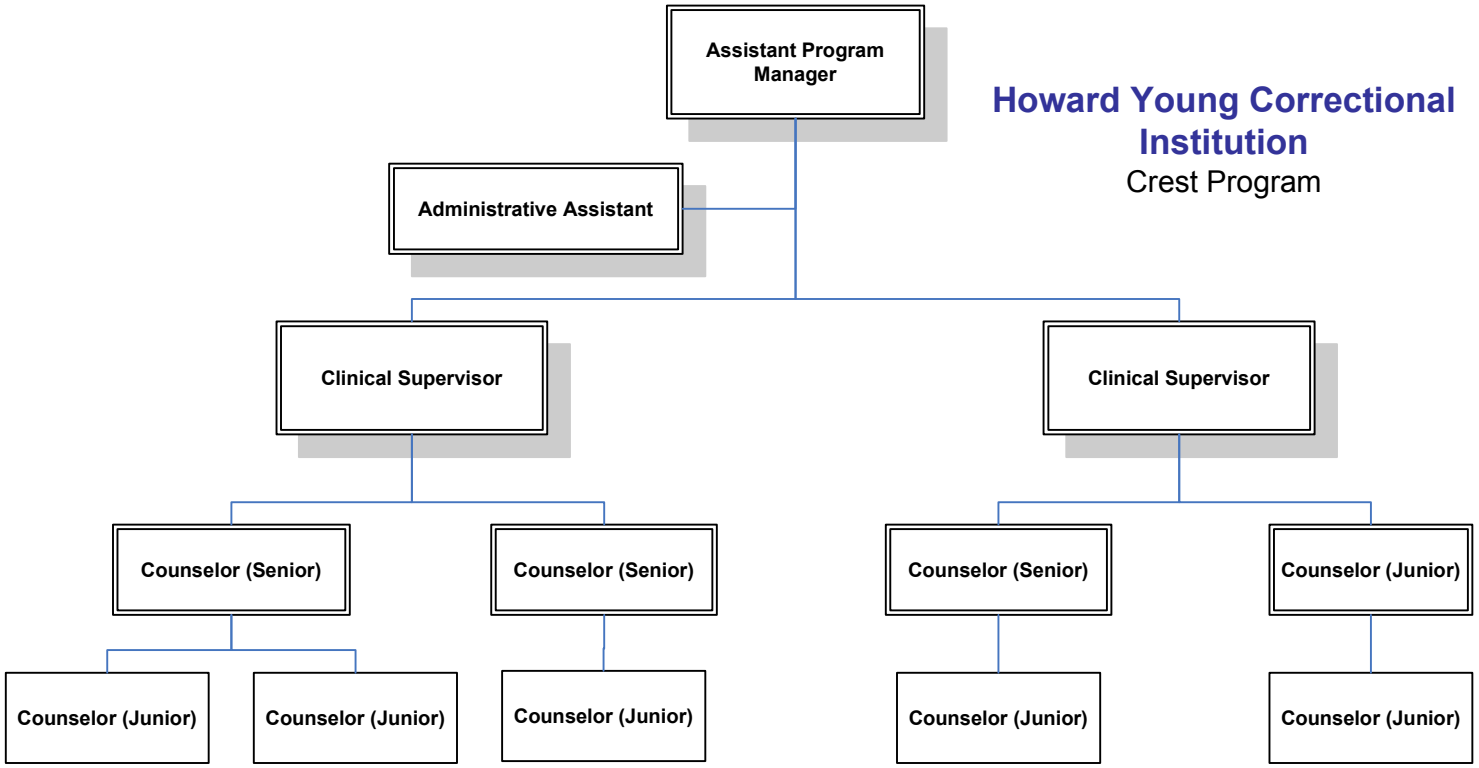


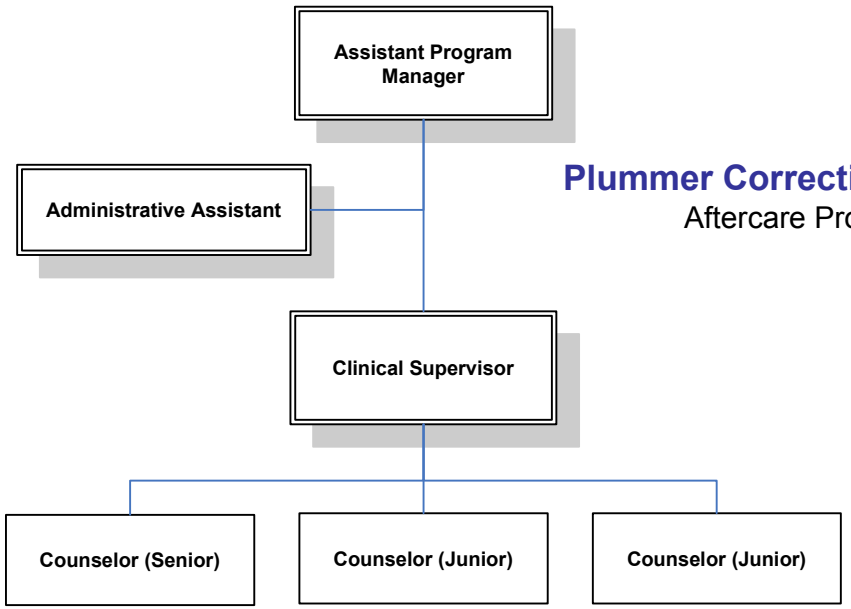
Morris Correctional Center

Aftercare Program

Howard Young Correctional Institution

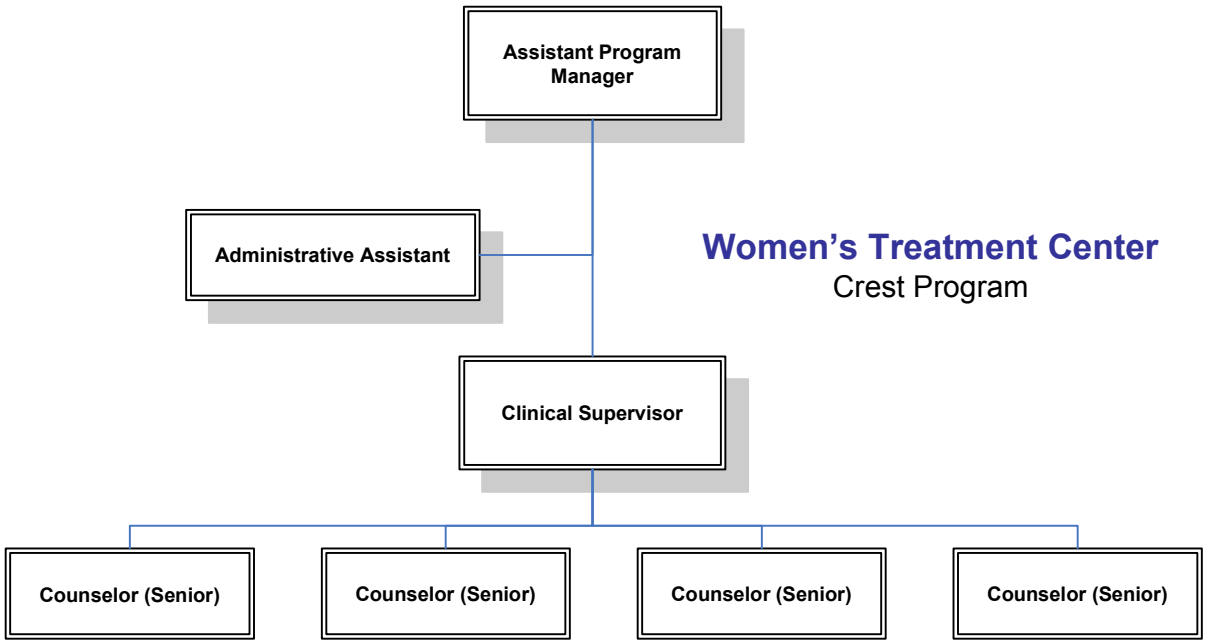
Crest Program





Plummer Correctional Center

Aftercare Program



Women's Treatment Center

Crest Program

Treatment Schedules: An example is provided of treatment schedules for both the KEY and Crest Programs. It is understood that the proposed schedules will be modified to meet particular institution schedules so that both security concerns and the need to provide as many treatment hours as possible can be accomplished.

LEVEL V RESIDENTIAL TREATMENT SCHEDULE							
TIME	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**SATURDAY**	**SUNDAY**
6:30 AM	FOF (*Feet on Floor)*Personal Hygiene	FOF Personal Hygiene	FOF Personal Hygiene	FOF Personal Hygiene	FOF Personal Hygiene		
7:00 AM	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast
7:30 AM	General Clean-up/Inspection	General Clean-up/Inspection	General Clean-up/Inspection	General Clean-up/Inspection	General Clean-up/Inspection		
8:00 AM	Morning Meeting	Morning Meeting	Morning Meeting	Morning Meeting	Morning Meeting	Morning Meeting	Morning Meeting
8:30 AM	TC Department Head Meetings / Study Time	TC Department Head Meetings / Study Time	TC Department Head Meetings / Study Time	TC Department Head Meetings / Study Time	TC Department Head Meetings / Study Time	General Cleaning	General Cleaning
9:00 AM	Seminar	Seminar	Seminar	Seminar	Seminar	AA, NA Meetings	AA, NA Meetings
9:30 AM							
10:00 AM							
10:30 AM	Group	Group	Group	Group	Group	Visits	Visits
11:00 AM							
11:30 AM	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch
12:00 PM	Break	Break	Break	Break	Break	AA, NA Meetings	AA, NA Meetings
12:30 PM							
1:00 PM	Group	Group	Group	Group	Group	Visits	Visits
1:30 PM							
2:00 PM							

LEVEL V RESIDENTIAL TREATMENT SCHEDULE							
TIME	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**SATURDAY**	**SUNDAY**
2:30 PM	Seminar	Seminar	Seminar	Seminar	Seminar		
3:00 PM							
3:30 PM							
4:00 PM							
4:30 PM	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner
5:00 PM							
5:30 PM	Mandatory News	Mandatory News	Mandatory News	Mandatory News	Mandatory News	Free-Time	Interactive Journal Study
6:00 PM							
6:30 PM	Interactive Journal Assignments	Interactive Journal Assignments	Interactive Journal Assignments	Interactive Journal Assignments	Interactive Journal Assignments		
7:00 PM							
7:30 PM	Free / Study Time	Free / Study Time	Free / Study Time	Free / Study Time	Free / Study Time		
8:00 PM							
8:30 PM							Free Time
9:00 PM							
9:30 PM							
10:00 PM	FOF (*Feet Off Floor)*	FOF	FOF	FOF	FOF	FOF	FOF

LEVEL IV RESIDENTIAL TREATMENT SCHEDULE							
TIME	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**SATURDAY**	**SUNDAY**
6:30 AM	FOF (*Feet on Floor)* Personal Hygiene	FOF Personal Hygiene	FOF Personal Hygiene	FOF Personal Hygiene	FOF Personal Hygiene		
7:00 AM	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast
7:30 AM	General Clean-up/Inspection	General Clean-up/Inspection	General Clean-up/Inspection	General Clean-up/Inspection	General Clean-up/Inspection		
8:00 AM	Morning Meeting	Morning Meeting	Morning Meeting	Morning Meeting	Morning Meeting	Morning Meeting	Morning Meeting
8:30 AM	Work					AA, NA Meetings Visits	AA, NA Meetings Visits
9:00 AM							
9:30 AM							
10:00 AM							
10:30 AM							
11:00 AM							
11:30 AM						Lunch	Lunch
12:00 PM						AA, NA Meetings Visits	AA, NA Meetings Visits
12:30 PM							
1:00 PM							
1:30 PM							
2:00 PM							
2:30 PM							
3:00 PM							
3:30 PM							
4:00 PM							

LEVEL IV RESIDENTIAL TREATMENT SCHEDULE							
TIME	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**SATURDAY**	**SUNDAY**
4:30 PM	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner
5:00 PM	Seminar	Seminar	Seminar	Seminar	Group Sessions	Free-Time	Interactive Journal Study
5:30 PM							
6:00 PM							
6:45 PM	Break	Break	Break	Break	Break		
7:00 PM	Seminar	Group Sessions	Seminar	Group Sessions	Seminar		
7:30 PM							
8:00 PM							
8:30 PM							Free Time
9:00 PM	Study Time	Study Time	Study Time	Study Time	Study Time		
9:30 PM							
10:00 PM							
10:30 PM							
11:00 PM	FOF (*Feet Off Floor)*	FOF	FOF	FOF	FOF	FOF	FOF